The Public Health Nurse

Volume XXII December, 1930 Number 12

Maternity and Christmas Number

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing, Inc.

Volume XXII DECEMBER, 1930 Number 12

A Christmas " Least One " on Hell-fer-Sartin

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Frontier Nursing Service, Hyden, Leslie County, Kentucky

Illustration by M. Oetjen

AT six o'clock on Christmas Eve the mountain darkness that descends so quickly in the Kentucky hills had completely surrounded the two small white buildings composing Possum Bend Center. The air was chilly and the nearby hillsides were being leisurely powdered by a gentle snowfall. Suddenly there gleamed in the darkness a light from a lantern, while the figure of a man astride a small, lean mule appeared at the wire fence enclosing the center grounds, and a man's voice shouted—" Hello, Hello, Hello—Nurses."

Before the last hello had found its echo, the door to the little white cottage was opened and one of the nurse-midwives, clad in riding clothes, appeared on the porch, holding aloft a kerosene lamp. She recognized the man as Sam Napier, and asked him to come inside and get warm. He refused, explaining that " Sally his wife was punishing turrible, and wanted the nurses."

Fifteen minutes later the two nurses mounted on their faithful equine friends, rode out of the white barn after the anxious young father. Both were acutely aware of the distance to be traveled before Sam's house could be reached. The Napier cabin was perched on the top of Devil's-Jump-Branch on the famous " Hell-fer-Sartin " creek. This is the roughest creek bed to travel either afoot or on horseback in Leslie county.

Patiently the two horses, Penny and Darky, followed the mule through the chilly waters of the creek. The snow continued, changing from gentle, fine powdery flakes to stinging icy granules that clung tenaciously to the sleek coats of the horses as well as to the heavy outer garments of the nurses.

Gloves or mittens are luxuries for a poor mountaineer. On this cold, snowy Christmas Eve, Sam's hands were bare. He frequently changed the lantern from one hand to the other in order to thrust his numbed fingers into the pocket of his shabby black overcoat. He often remarked " Hit's a powerful bad night, and a heap of trouble for ye to come this fur, but Sally she allowed hit were time fur you

all to come. She always knowed with the boys, so I reckon she needs ye."

The nurses took turns in assuring him that this night journey was just part of the day's rounds. They quoted the motto of the Frontier Nursing Service adopted since its earliest pioneer days: "No matter what the weather, if a father comes for the nurse she will return with him."

On a sunny day the six mile horseback journey would have taken an hour and a half. The blackness of the night, together with the heavy snowfall kept the horses going at a slow walk. Three hours passed before the first cabin on Devil's-Jump-Branch was reached. The last half mile was up the particularly steep, rocky incline long ago christened by the early settlers "Devil's-Jump." When this point was reached, the nurses dismounted in order to lead their weary horses up the slippery path ending at the door of Sam's tiny weather-beaten log cabin.

The kindly neighbor women who had come to sit with Sally during her confinement had heard the horses coming and had opened the door to call out a warm welcome to the tired travelers. Sam took immediate charge of the horses and assured the nurses that the barn was warm and dry.

One of the women seized the saddle bags and carried them into the cabin. Friendly hands peeled off the nurses' wet wraps and spread them out to dry before the brightly blazing log fire which, together with the light from one "coal oil lamp" illuminated the combined bed and living room. The whiteness of the pine board floor, as well as the orderly arrangement of the handmade rustic furniture would have made a lasting impression on even a casual visitor. The walls had been freshly papered with pages from the *American Journal of Nursing* and THE PUBLIC HEALTH NURSE. How vividly the nurses remembered the bleak, wet autumn afternoon that Sally had knocked at the clinic door with five pennies saved from her egg money for the purpose of purchasing enough magazines to repaper the interior of her home! The only periodicals on hand in the Center were the previous year's nursing publications. Sally had greatly admired the smoothness of the paper and the size of the pages.

The sooty black iron tea kettle used in every mountain home was waiting on the hearth filled with boiled water. Several small tin lard pails had been assembled on the table for the use of the nurses. One of the beds had been made with clean sheets. Blankets were unknown in this humble mountain home. There was, however, a plentiful supply of clean, hand-pieced quilts of various weights, patch work patterns and brilliant colors, turkey red predominating.

The nurses opened the midwifery saddle bags and laid out the necessary equipment for the delivery.

Sally had since her marriage at sixteen always been known as the "sewinest and workinest woman on the creek." She had taken great pride in making the baby clothes from modern patterns furnished from the Center.

Silently and patiently this young twenty-six year old mountain mother labored. The women folk encouraged her by relating the story of the first Christmas baby. When she became restless they admonished her to "do what these women tell ye, because they know what's best for ye."

Shortly after midnight the first Christmas baby on "Hell-Fer-Sartin" made her appearance crying lustily. How her parents rejoiced at the birth of a daughter because the other four were sons. The nurses were given the privilege of choosing the name for this tiny black-haired daughter. They consulted together and suggested Noel Mary as a name for Sally's "least one." The name pleased the parents. After Sally had given her daughter a keen look and learned her weight was eight pounds, she reckoned she was "a right pert young un."

Meanwhile Sam had raised the door in the ceiling leading to the loft above where the four boys were snuggled together in one bed and informed them

that they had a little sister. The nurses were urged to "take a night" and share the other bed. However, the snow had ceased and the moon had come up flooding the snow clad slopes with magic light, so the hospitable invitation was refused. Sally was assured that a nurse would return to care for her that afternoon. One of the elderly neighbors had offered to remain for a week to look after the little household, so instructions regarding the care of the mother and baby were given her.

After everyone had partaken of a steaming cup of black coffee and Christmas greetings had been exchanged, two weary but elated nurses mounted their horses and rode away. It was then two o'clock in the morning and brilliant moonlight was glistening on the snowy hillsides. In the peaceful beauty of the snow-powdered hills and with the memory of the happy family in the tiny, isolated mountain cabin, the fatigue and cold were forgotten. The nurses lifted their faces to the star sprinkled sky and their silent thoughts were—"Noel Mary Napier—a Christmas baby on Devil's-Jump-Branch, Hell-Fer-Sartin Creek — He came, that first Christmas Babe, that you too might have life and have it more abundantly."

The Nurse's Responsibility for Care of the Maternity Patient

By MARION H. DOUGLAS, R.N.
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OUR high maternity death rate and a recognition of the need for better maternity care, are perhaps receiving greater consideration than ever before. The type of care being given by organizations fostering such interests, and the individuals responsible for the conduct of the service, are all receiving their share of attention. The questions repeatedly coming to us are:

Is maternity care, as given at present, adequate?

What is the content of good maternity care?

With whom does the responsibility rest for the actual care of the patient, education of the mother, the securing of her coöperation in returning for postpartum examination?

By what criteria can we measure or evaluate our maternity service?

The answer to these and similar questions is believed by many to contain the keynote to our present maternity problem. It is in response to this rather general appeal for a measuring rod for maternity service that *Standards for Maternity Care* have been set up by the Committee on Maternity Care of the Children's Welfare Federation and a Committee appointed by the Council of the New York Obstetrical Society.*

In the preparation of these *Standards,* the Committee recognizes that:

There is a variation in the technique, administrative policies, and physical arrangement of hospitals and clinics, as well as in the facilities of the private practitioner's office.

Institutional and private care of obstetric cases overlap in varying degrees.

Certain minimum requirements for the conduct of obstetric cases are applicable with modifications to organizations and individuals engaged in the practice of this branch of medicine.

Adequate maternity care for all mothers in any community presupposes the acceptance of such minimum requirements by all institutions, organizations and individuals giving any maternity service.

* Published by the Children's Welfare Federation, 244 Madison Avenue, New York City.

The aim of adequate maternity care is the minimum of mental and physical discomfort for every woman during pregnancy; the maximum of mental and physical fitness at its termination, with the reward of a well baby and the knowledge whereby she may keep herself and her baby well.

Standards developed with institutional practices in mind are as a whole adaptable to private practice with certain minor changes and omissions.

Every organization and individual giving maternity care, should make a conscientious effort directly or indirectly to teach the community the value of and the need for medical and nursing care from the time pregnancy is suspected.

While independent centers giving prenatal care are at times necessary, it is important that such centers have a definite working agreement with hospital services, for the reception of patients and their subsequent treatment.

It would appear desirable for each community to establish a local committee on maternity care, made up of interested professional and lay groups or individuals. This committee should serve as a clearing house for information, should endeavor to develop improved facilities for obstetric care where these are deficient or lacking, and should stimulate the adoption of uniform standards by those engaged in maternity work.

Any program for adequate maternity care includes adequate nursing service. The success of such a program depends, in no small measure, upon the relationship between the medical and nursing groups undertaking such a program. Continuity of service to the patient is the keynote of maternity care and the responsibility of the nursing group is equally recognized in prenatal care, delivery service and after-care.

PRENATAL CARE

In addition to a general physical examination by a physician early in pregnancy and regular visits to the physician throughout pregnancy there are certain specific services which should be available to patients during the prenatal period:

Group teaching in prenatal clinic which will instruct the mother in the care of herself, the preparation for delivery and the care of the baby upon its arrival, covering:

Hygiene of pregnancy.
Care of the breasts.
Diet of the pregnant and nursing mother.
Clothing for the pregnant woman.
Clothes for the baby.
Bathing and care of the baby.
Habit formation for baby.

Arrangements for referring of clinic patients to other institutions equipped to give the desired care which for any reason cannot be given by the institution or organization first approached.

A carefully integrated medical-social plan for clinic patients, by developing a contact between the clinic and the patient which will help to solve any social or economic problems which may affect the health and peace of mind of the patient or prevent her following instructions.

Home visits by a supervised public health nurse in accordance with the physician's instructions. Unless otherwise indicated, such visits should include:

Checking the condition of the patient.

Determining the needs of the patient in relation to her home condition to help solve any social or economic problems which may affect the health or happiness of the expectant mother.

Advising about the preparation for delivery if home delivery is planned, or to help make any plans which may be necessary if patient is to go to the hospital, such as placing children, arranging about husband's meals, etc.

Arranging for supplementary care at time of delivery and during postpartum period.

Instructing the patient regarding the symptoms which indicate the onset of labor and informing her of the importance of reporting to the doctor or the hospital if these come on. (Rupture of membranes, even without pains being present, call for attendance of doctor or visit to hospital.)

It is felt that the nurse's visit is of value only if she sends a report of her findings and advice on each visit, to the hospital or doctor caring for the patient.

DELIVERY CARE

The conduct of labor and the responsibility for the care of the patient during delivery rests with the physician. It is imperative, however, that there shall be adequate nursing service from the beginning of labor.

An attempt should be made to maintain the same standards in home deliveries as in hospital deliveries, and the nursing service in either instance should include certain essential features:

The patient should be under constant observation throughout labor.

If home delivery, the nurse should respond immediately to the call.

If hospital delivery, a nurse should be assigned to give her undivided attention to the patient throughout labor.

The nurse should be responsible for:

Keeping the patient as comfortable as possible, and doing everything to allay her fears and conserve her strength.

Watching the progress of labor carefully, recording every half hour the fetal heart rate, the patient's pulse, the frequency and duration of pains as well as the time of rupture of membranes and anything unusual in the patient's appearance or manner.

Keeping the physician informed of the patient's progress, getting in touch with the physician at regular intervals if the physician should be called away during labor, or is otherwise detained.

Preparing the patient for delivery.

Giving nursing assistance at delivery.

AFTER CARE

Care of the mother and baby after delivery should include careful inspection and supervision and every effort to guard against complications. While such supervision includes "visits by the physician as often as may be needed and at least on the first, fifth, seventh and tenth days if the patient is at home," the physician relies upon the nurse to:

Give daily care to mother and baby.

Inspect breasts daily.

Give or instruct someone in giving perineal cleansing and dressing according to approved method, after using bedpan and as often as necessary.

Make detailed observation of the patient including temperature, pulse, respiration, with immediate report to physician of any abnormalities or change in patient's condition.

Instruct mother regarding the need for regular medical supervision for the baby, establishment of daily routine for the baby in terms of its environment, need for postpartum examination by the physician.

Granting that the care of the patient is the goal toward which we are working, it is generally conceded that this care can only be effectively administered with well trained personnel.*

* The detail as to qualifications of staff may be found on page 22 of the report: *Standards for Maternity Care.*

MATERNAL MORTALITY IN THE REGISTRATION AREA: 1929

The Department of Commerce announces that for the birth registration area the mortality from puerperal causes (7.0 per 1,000 live births) in 1929 was only five-tenths higher than the rate (6.5) for 1927, the last year for which the summary was published. Puerperal septicemia was affected even less, the rate for 1927 having been 2.5, as compared with 2.6 in 1929, and the rate for "other puerperal causes" was lowered to 0.3 in 1929. These maternal rates are based on the number of deaths among women 15 to 45 years of age per 1,000 live births.

Confining the discussion to only three groups, namely, "all puerperal causes," "puerperal septicemia," and "other puerperal causes," it will be noted that of the 46 states for which data are available for 1929, South Carolina had the highest mortality rate (11.4), with Alabama and Louisiana next in order (each 9.9), Florida (9.5) and Georgia (9.3). It must be borne in mind, however, that all the states with excessively high rates have large proportions of colored populations. Singularly, the states with high rates from "puerperal septicemia" are Montana (4.2), Colorado (4.0), New Mexico (3.9), and Arizona (3.8), all with vast rural areas sparsely settled, where hospital facilities and skilled medical care are difficult to procure.

The Department of Commerce has also published a table of birth rates and infant mortality rates by states, covering the years 1915–1929 inclusive. While the infant mortality rate (68) was the second lowest since the establishment of the birth registration area in 1915, the birth rate for 1929 (18.9) was the lowest for any year since that date. In the majority of instances, high infant mortality rate and high birth rate coincide, notably in the southern states where negro population is dense.

Mental Health Hints for the Prenatal Period

By Winifred W. Arrington
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SUCCESSFUL mothers do not just happen. They are women who learn the art of mothering, who prepare for each new phase of maternity as it comes. To be sure, the art of mothering becomes more complex all the time. The safeguarding of the child's physical welfare alone is a many-sided, challenging problem, and lately we are discovering that grave new obligation of parenthood, the responsibility for mental health. Thanks to prenatal clinics, well baby clinics, school examinations, and the broad program of the public health nurse, to say nothing of the invaluable work of the physician's private office, the average mother is now met more than half way in the effort to give her baby sound physique. But resources for mental hygiene—by comparison, at least—are still in embryo, and it is the skill and wisdom developed by the mother herself which continue very largely to determine the measure of her baby's mental health.

Actually, preparedness on the mother's part is never more imperative than in relation to the child's mental and emotional life. Little as we know at present about our needs as personalities, we know that these needs do not emerge all of a sudden when we enter school, or when we begin to talk, or at any other of those turning points in development at which we make definite overtures to the world about us; rather, there is perfect continuity in our mental development, as there is in our physical. One experience follows upon another, and the habits and attitudes which we assume toward our experiences are patterned upon the habits and attitudes of our past. And so, psychiatrists tell us, the earliest stages of the baby's career are the most significant.

Even the prenatal period has its bearing upon mental health. If the mother is agitated and overwrought, her whole system feels the strain and is affected accordingly. Furthermore, the attitudes with which she meets her pregnancy are quite apt to persist in some form after the baby comes, influencing him and her relationship with him. If they are unwholesome attitudes, they may interfere at the very beginning with the baby's normal emotional tendencies, and so hamper him all his life.

The mother cannot possibly have too much help, therefore, in making the period of pregnancy and the early postnatal period serene and wholesome. Her family and friends can do a great deal to keep the home atmosphere cheerful, but no one, perhaps, shares the exceptional opportunities of the nurse for fostering her mental health and laying a secure mental hygiene foundation for the baby. The nurse, because of the special prestige which attaches to her profession, and because of all that she stands for in terms of comfort and dependability, is in a peculiarly strategic position. What she says and does is likely to carry great weight. But to take advantage of her privileges may sometimes necessitate departing a little from the routine of nursing care and seeing the patient from a new perspective. It may mean a certain amount of compromise, for now and then the interests of obstetrics may have to be subordinated to the human factors present, but the clever nurse will readily learn to harmonize the human and professional factors in her "case," and will find rare satisfaction in cherishing her patient's morale.

Perhaps the prenatal period is particularly prone to give rise to undersirable attitudes. At any rate, the nurse will frequently encounter in the expectant mother more than one re-

grettable turn of thought which adds to the stress of pregnancy, and which in some cases may lead to serious emotional disturbances. Of course, not all of them are relievable. Worry about genuine financial difficulties, for instance, is by no means easy to combat, particularly in these days of unemployment and economic upheaval, and any attempt to belittle a patient's concern about the family income or the expenses of her confinement may be more harmful than otherwise. Dread of childbirth on the part of a mother who knows that she has physical handicaps like a serious heart condition is equally baffling. Such wholly reasonable anxieties are not to be confused with the worry that comes from exaggeration of ordinary physical or financial liabilities; they are quite distinct, representing bits of reality which cannot be ignored or modified. With all possible honesty and courage the patient must face them, and the nurse's contribution must be that of keeping her from morbid absorption. The nurse who proves herself a tactful and sympathetic listener, but who at the same time is skillful enough to introduce new interests and turn the mother's attention in happier directions, is probably meeting the situation as well as it can be met.

But not all of the unfortunate attitudes of the expectant mother are inevitable. Those that spring from ignorance and misapprehension and those that originate in selfishness can be overcome to a goodly extent or even eliminated altogether. There is, for one, that stubborn old bugaboo, the fear of "marking" the baby. All our scientific progress notwithstanding, this fear is still remarkably prevalent. The needless misery caused by it is beyond measuring, for not only are there the mother's panic or false hopes to consider; there is also the deplorable effect upon the child of growing up in a home where his fate has been settled irrevocably before he is born, where every misstep is set down as only expected. The nurse can play a vital part in dissipating this old prejudice, but she will do well to arm herself, not only with the accepted arguments against it, but with a more than usually tolerant mind. The more absurd and extreme the mother's belief may appear in the light of her own scientific training, the less readily is she likely to yield, and only the nurse whose patience is equal to more than one kindly and quiet explanation can hope to have real influence.

Then there is that closely related fear that has to do with heredity. Many are the mothers who distress themselves lest the baby inherit his father's temper tantrums, his mother's clumsiness, his Aunt Mary's lisp, or what not. To these mothers the nurse can offer mental hygiene in concrete terms of habit training. Science is so comforting about heredity nowadays that she can readily assert that no such specific traits or mannerisms are possibly inheritable, but she will miss an opportunity if she does not point out at the same time that the baby is an amazing little imitator, and that it behooves his parents to watch the example that they set. If Father indulges in temper tantrums, and incidentally reduces the family to submission by them, Sonny will be quick to reproduce the same behavior. He will learn to use tantrums as he learns to use a cup and spoon, and his angry demonstrations will have no more than his table manners to do with heredity. Instead of fretting about whom the baby may "take after," the mother can look ahead and plan his training wisely, doing thereby all that is humanly possible to influence his disposition favorably. To this end, the nurse may be able to put her in touch with organizations like the Child Study Association of America, the National Committee for Mental Hygiene, and others, which can recommend pertinent reading on the subject of child guidance, or can give her concrete suggestions about her own baby.

Among the very common apprehensions of the expectant mother are, of course, those associated with the physiological changes of pregnancy

and the ordeal of labor. Sometimes the case is one of lacking information and of a dread that proves quite groundless in the light of the nurse's patient interpretation. In other cases the facts are too well appreciated, and the mother experiences not only the normal recoil from pain and discomfort, but a harrowing fear of accident which keeps her in constant excitement. It is the patient who is enduring her first pregnancy, perhaps, who is especially susceptible, and she is often, unfortunately, at the mercy of injudicious older women who attempt to advise her on the strength of other people's experiences. Stories that begin, "Now when my baby came," are too apt to be unconsciously dramatic. They have the disquieting effect of all housewives' tales and should be taboo, but naturally, they are not easy to prohibit, and the nurse may find herself hard put to counteract them. It may be that her best line of attack consists in appealing to her own wealth of observation which the patient is bound to respect. The reassurance of one who knows, as the nurse does, how seldom nature blunders in childbirth if the mother has good prenatal care, and how miraculously the human body responds to new demands, ought to go far to allay any unreasonable dread, and restore the patient to a philosophical attitude.

Akin to the fearful moods of pregnancy are those of self-pity. These, up to a certain point, are more or less understandable. Assuredly, the modern girl, once having tasted the freedom of professional life and of independence in general, can scarcely be expected to resign her privileges without a murmur. Since our grandmothers' time, when a woman's life centered almost entirely about childbearing and child-raising, there have been drastic social and economic changes, as everyone admits. This generation cannot be invariably acquiescent about having a baby, for having a baby has become an immensely complex undertaking, and one that entails no small amount of sacrifice. And so, for the woman who regards her pregnancy as a sad predicament, there is a good deal to be said. She is not necessarily radical or self-centered or irresponsible or selfish. She is essentially a person who knows her limitations.

That all women at heart want babies is an assumption that is rapidly being exploded. Evidence to the contrary is too strong. As a matter of fact, we are forced to conclude that the maternal feeling, which every girl has been supposed unerringly to possess, is as much cultivated as instinctive, and may be lacking altogether. Women whose circumstances in no way deter them from having children, are electing to remain childless, and many of those who do bear children seem alarmingly devoid of the tenderness that has always been associated with the function of motherhood. Among certain groups there is a concerted effort to avert pregnancy, so far as possible, and pregnancy, when it occurs, is repeatedly greeted as a veritable calamity.

But self-pity only makes the situation worse. From the standpoint of mental hygiene it is an exceedingly sorry sign. The mother who assumes a martyr's rôle during pregnancy is apt to cling to it after her baby comes, with results that for him may be disastrous. He then symbolizes the barrier between her past and her present, becomes the personification of her handicap. Naturally, he begins life with a burden of blame and a sense of frustration. He cannot hope for any degree of protectiveness or understanding from her, for the usual healthy interchange of affection is impossible, and the normal mother-child relationship has never been established. Moreover, the part which self-pity plays in producing neurotic reactions is something which psychiatrists readily point out. Everybody knows the distressing person who has "never been the same since her baby came"; she is still unconsciously glorifying herself for having borne a child, and using the fact that she once performed this special physiological feat as an excuse for not meeting the obligations that are

properly hers. She has lapsed into an agreeable invalidism which exacts of her only what she wants to do, and which usually enables her to escape responsibility for her baby quite effectually. Not that these self-pitying women are deliberate conspirators, for they are not. Oftentimes, they are persons who have never quite grown up to their responsibilities, and who unconsciously retreat from demands that threaten to overwhelm them. Or they may have an uncontrollable aversion to motherhood as such. Or self-pity, although at first a mere protest against unwelcome circumstances, may have fastened upon them as a habit. Some of them, to be sure, cannot be reached by any ordinary measures, but the nurse who recognizes the dangers in self-pity, and finds it impossible to distract her patient, may render timely service by enlisting the help of a psychiatrist.

Sometimes the reaction to pregnancy is much more vehement than self-pity. If the baby means an irritating interruption to a career, an intruder between husband and wife, a restriction on sports and social activity, or merely one more hungry mouth to feed, the mother may respond with downright bitterness. What the circumstances may be, and what may be their ethical or moral import, is, for mental hygiene purposes, irrelevant. For the mother and for the baby—and for the nurse, who is concerned for them both—the only material fact is that the mother resents her pregnancy and is in a state of emotional turmoil. Here is an instance in which the nurse may find it necessary to set aside for the time being not only her personal but her professional convictions. To be of real service, she may have literally to sympathize, that is, feel with her patient, follow her reasoning and sense her motives. She need be guilty of no insincerity; the gentle art of sympathy requires only understanding. But the patient may need desperately to know that her plight is appreciated, that regardless of the desirability of babies in general, somebody comprehends that a baby for her may be tragedy.

There is no possibility of converting the mother by argument. To argue the right or wrong of the case in face of her resentment, is worse than futile, for resentment, like every other emotion, resists logic. Emotion can be fought with emotion, however. The patient's sense of humor can be enlisted, for one thing; her pride, for another—not pride in her baby, but pride in her own self-command and self-respect. Let her have as many outlets for her energy as possible. Keep her supplied with interesting things to do. And, gradually, as the bond of confidence and understanding between nurse and patient strengthens, there will come to the mother a realization of the devastating effect of her revolt. With the insight and perspective that will develop out of the change in her current of thought, she may even begin to see what poor sportsmanship it is to make the baby the victim of her disappointment, and of her own accord she may begin to exert herself in his behalf.

At this point it is important to make sure that she does not go to another extreme, and acquire a sense of guilt at the memory of her rebellion, for her zeal to atone can easily be as unfortunate as her first bitterness. It may have the same effect as the mistake of the mother who craves her baby too intensely. The longed-for child may be desired as a means of holding the home together or of recapturing the interest of a neglectful husband; he may represent a hope of retrieving lost opportunities and living life over again, or merely an extension of the mother's own personality, and a means of realizing at last her unexpressed ambitions. Any of these motives is likely to be more unconscious than conscious, but they all lead the mother to look forward to her baby's coming in a possessive spirit and to receive him as someone whom she may manipulate and direct.

The possessive type of mother sins

very specially against the child's personality. For what hope is there for the boy or girl who is supervised at every turn, and given no opportunity to develop spontaneity or initiative? He becomes only a reflection of his parents. It is not difficult to recognize these products of mother-domination. In adult life they are mere shadow people. No matter how much native intelligence they may have, they are never able to give it free expression, for they have never learned to act for themselves. And so, when a mother is found awaiting her baby with this yearning for ownership, no effort can be spared in enlightening her. In many cases it will prove that the help of experts is necessary, for her problem is presumably rooted deep in her own emotional life. But even so, the nurse may be able to contribute a practical touch here and there that will make it less acute. What this type of mother badly needs is to cultivate new interests and throw herself into other activities so vigorously that they will absorb her even after the baby arrives. The baby must not be the sole end and aim of her existence; there must be other strong attractions in her scheme of things that compete with him for her attention.

Ideally, the prenatal period is a tranquil and satisfying interval, and many women find it so. For every mother who adopts unfortunate attitudes, there are perhaps two who meet it sensibly and happily. These mothers neither resign themselves helplessly to their "condition," as if life had ceased to flow about them, nor storm against it. They keep active and cheerful. And it is they who demonstrate how possible it is for the mother to preserve a fine emotional balance herself and to bring her baby into the world under wholesome, kindly auspices. Some of these women enter just as wisely upon the early postnatal period, though others do not fare as well.

(To be continued in January)

NEWS FROM JOINT VOCATIONAL SERVICE

Fewer positions are available for public health nurses and there are more candidates than there have been for a long time, according to the experience of Joint Vocational Service. The number of positions secured in 1930 by public health nurses registered at Joint Vocational Service, however, is slightly in excess of those secured during a corresponding period in 1929. There are still not enough well-qualified public health nurses to fill positions requiring a special type of preparation. Neither are there enough nurses available for rural openings.

In the executive field, there is little turnover at present. Whereas two years ago six candidates were interested in each executive opening, today about twenty are interested, comparatively few of whom are without positions. Executives are urged to retain their positions, if possible, until finding others. Industrial positions, always few, are at a standstill, and a number of industrial nurses have been seeking other kinds of opportunities.

Securing a position at this time of unemployment is more than ever dependent upon the right personality, preparation, and experience of the public health nurse. Also, the question of attitude is a factor. Willingness to adjust to a trying time by taking a smaller job in good spirit is helping many public health nurses to pass through the crisis.

CHRISTMAS CARDS

The International Grenfell Association is again selling Christmas cards for the benefit of the nursing, medical and social work in Labrador and Newfoundland. There are three designs—two of them by Sir Wilfred himself—and three prices: a polar bear greeting a baby seal with "Merry Christmas" (15 cents), a card depicting the brotherhood of beast and man (10 cents), and three little children carolling and wearing the Grenfell dickies (5 cents). Cards may be secured from the Association's headquarters, 156 Fifth Avenue, New York City.

Industrial Nursing Service Provided by a Public Health Nursing Association *

By Erna Kowalke
Director, Visiting Nurse Association, Milwaukee, Wis.

THE Milwaukee Visiting Nurse Association was organized in 1907. It was directed by a group of representative men and women of our community who were interested in all forms of public health nursing. The value of a nurse in a public health program not having been previously demonstrated, it became the privilege of the Visiting Nurse Association to prove to the community the need of bedside nursing, infant welfare work, school nursing, follow-up visits to tuberculosis cases, hospital social service and industrial nursing. Gradually, the Association relinquished to the city health department the infant welfare, tuberculosis and school nursing services. These have been financed and directed by the Department of Health for more than fifteen years.

SERVICE TO INDUSTRIAL PLANTS

In 1909, the Visiting Nurse Association placed the first nurse in a local industrial plant for the purpose of demonstrating to the employer the economic value of a public health nursing service. No special effort has been made by the Association to develop this industrial nursing service through solicitation. Six nurses are now giving full time to five different plants, one nurse giving part time service. The industries represented in this affiliation are two tanneries, one glue company, one plate glass and paint company, one dairy company, each employing one nurse, and an automobile body corporation, employing two and three nurses. The contract made with these companies is on a yearly basis. The agreement provides that service may be terminated by either party on a written notice of thirty days. It also provides that the Association protect the nurse, while on duty, with a liability insurance.

ADMINISTRATION OF THE SERVICE

The nurses make their headquarters at the plant, reporting there directly each morning at 8 o'clock. Their services vary according to the nature of the industry: one industry requires the services of two and three nurses on full time for the physical examinations and first aid. Whenever these nurses feel the need for a visit in the home of an employee the case is referred to the Visiting Nurse Association headquarters, and the call is assigned to the nurse working in the district where the patient lives. The district nurse making the call is responsible to the plant nurse, reporting the result of her visit directly to her.

In other plants where the physical hazards are not great and a smaller number of persons are employed, the nurses find it possible to arrange a schedule for definite hours in the plant for first aid and consultation service and another schedule for visiting in the homes of the employees. An industrial nurse making her own visits in the home of employees is in a position to recognize the reason for some of the problems the employee has had in the plant, such as frequent accidents, minor illnesses, inefficiency, absences, etc., which may have been due directly to his home environment.

The industrial nurse submits to the Visiting Nurse Association a monthly report of her activities. These reports are made in duplicate: one is filed in the office of the Association, the other sent to the employer. The case record of the employee is, of course, filed in the plant and considered plant property.

* Paper read at the N.O.P.H.N. Round Table on Industrial Nursing, Biennial Convention, Milwaukee, Wis., June 12, 1930.

THE ADVANTAGES TO THE EMPLOYER

An industrial plant management affiliated with a public health nursing association has the assurance that the nurse assigned to his plant will have had the training in public health nursing and social service work to qualify her for the responsibilities he may want her to assume in his plant. If he is a progressive employer he will want the nursing service for his employees to be something more than an aid to the physician in first aid work. He will want the nurse to be an educator for the factory personnel and their families in the prevention of disease, and the importance of personal hygiene.

The progressive employer is aware that the rôle of an industrial nurse differs from that of the hospital and private duty nurse, and that a nurse who has had the added experience and training of a public health nurse is better qualified to meet his plant requirements. The staff nurse has demonstrated to the public health nursing association not only her ability as a public health nurse but also her ability to take initiative and to get on with people. The choice of the nurse rests with the executive of the public health nursing association, thus relieving the employer of the duty of interviewing applicants and reviewing qualifications. Should the employer for any reason not approve of the selection made, he may voice his disapproval, knowing that the necessary adjustment will be made. His affiliation with a public health nursing association avoids unnecessary delay in the selection of a nurse or any interruption in the quantity or quality of service due to illness, change of personnel, etc. The service to his plant and employees will therefore be more direct and consequently of greater economic value.

In small plants where full time service of the nurse is not required, as much service as needed may be had through the local public health nursing association. Group work is the order of the day, and several small plants organized as one unit could be served by one nurse. Since each plant manager usually prefers the morning hours for this service, this arrangement presents its difficulties, and the nurse may find it impossible to make her visit to the plant at the hours desired and give the time required in each plant. Mutual benefit associations of the company may be interested in a visiting nurse service for their members and their families. An arrangement may then be made with the local public health nursing association for the service of one nurse or they may purchase the nursing service on a visit basis.

THE ADVANTAGE TO THE NURSE

The industrial nurse affiliated with a public health nursing association retains all the privileges of other association staff members. With these staff privileges she is also under obligation to maintain the standards and carry out the policies and ideals of the association. This relationship does not change the general character of her services to the plant, provided the services remain within the field of public health nursing and social service, and that the first aid procedure is under the direction of a plant physician who will endorse the standing orders for treatments. The nurse is given the opportunity to develop her service as freely as her ability and the plant management will permit.

The nurse assigned to industrial service has, of course, the privilege of consulting anyone within the public health nursing association whether that be a member of the board of directors or one of the supervisory staff. Whenever her work permits she attends staff meetings, and uses the service available to her through the educational department of the association.

In time of illness she can depend on the association to provide as a substitute a staff nurse who will have the necessary experience to carry on her work with a minimum amount of confusion to the plant, thus relieving her mind of anxiety as to her work. During a period of financial depression a

nurse may be released by the industry. When this occurs the nurse is absorbed into the general work of the association, thus removing the fear of unemployment and the necessity of securing a new position. The assurance of this moral support helps to keep up her interest and provides a source of inspiration in overcoming problems and difficulties that frequently arise in her work.

ADVANTAGE TO THE ASSOCIATION

The financial gain to the public health nursing association in offering this service and staffing medical departments in industrial concerns is negligible. However, the organization has a definite professional and community interest in considering the project.

First, the organization is able to give student nurses who affiliate with the association an opportunity of receiving instruction and observing industrial nursing. The student may have some theoretical knowledge concerning industrial diseases and hazards and the safety program carried on in industry, but to see the program in operation and observe the part the nurse takes in this is obviously more impressive, giving her greater appreciation of the industrial nurse's responsibility in the prevention of disease and accidents.

Second, the community is constantly calling upon the public health nursing association to supply nurses in various public health fields, industry being one of these fields. The public health nursing organization is eager to have each nurse it sends out properly prepared to meet the needs of her position. Although the public health nursing association maintains an educational department for the preparation and continuous development of the nurses on the staff, it seems logical that an organization having industrial nursing in its program of activities should be able to supply better prepared nurses when called upon by outside industries. The value of this contribution is reflected in the quality of nursing service in industry whether or not the industry be affiliated with the public health nursing association.

As we go to press hundreds of social and health workers are clearing their desks preparatory to leaving for the President's White House Conference on Child Health and Protection to be held in Washington, D. C., November 19-22. From the deliberations of this great body of experts, public health nurses are looking forward to recommendations which will be of practical help in their community programs. The Conference report as it touches the facilities and opportunities for rural children will be of particular interest.

The Relation of the Nurse to Maternal, Infant, and Preschool Health *

By Richard Arthur Bolt, M.D., Dr.P.H.
Director of Cleveland Child Health Association

MY purpose in this paper is simply to outline briefly the present situation of maternal, infant, and preschool health in the United States and to place before you as public health nurses the major problems. Some suggestions are offered also as to practical measures available for bettering conditions today. The facts concerning infant and maternal hygiene are sufficiently clear to be stated categorically.

THE FACTS OF THE SITUATION

1. During the past fifteen or twenty years there has been very little, if any, reduction in the maternal mortality rates throughout the birth and death registration areas of the United States. Certainly not enough reduction has taken place to give us comfort for the large amount of money and thought expended on this problem. The maternal mortality rates have remained uniformly high in spite of marked improvements in sanitary conditions and availability of medical facilities. During this period there has been an increase in the number of confinements in hospitals and a proportionate decrease in the number of cases attended by midwives. The very same causes of death predominate today as appear in the records of fifteen and twenty years ago, namely, puerperal septicemia, the toxemias of pregnancy, hemorrhage, and accidents at birth. With all of our knowledge concerning infection accumulated since the days of Holmes and Semmelweis, puerperal sepsis continues to be a leading cause of maternal deaths. Recent studies of maternal mortality indicate that 30 to 40 per cent of the deaths follow abortions.

2. While we possess statistics which indicate the prevalence of maternal deaths, we are at a loss to know the extent of damage suffered by mothers who survive childbirth. We can gain a general idea of its extent from the large number of cases that come to our gynecological outpatient dispensaries and to hospitals for operations. The major part of the gynecological service rendered today is made necessary because of damage done during confinement, from abortion, and venereal disease, notably gonorrhea. Much chronic invalidism, nervous instability, and inability to bear the strain of modern life undoubtedly result from unfavorable conditions following pregnancy.

3. There has been practically no reduction in the neonatal mortality and stillbirth rates during the period for which we have reliable statistics. Death rates from abortion, prematurity, and accidents at birth have actually been on the upgrade. There has been no reduction in the neonatal deaths from congenital malformations. Although we have a practical method for the detection and treatment of syphilis in the pregnant mother, the number of abortions and cases of prematurity resulting from syphilis is altogether too great. It must be admitted that in places where the routine Wassermann is carried out and intensive treatment is instituted during pregnancy, the early deaths from syphilis have been greatly reduced.

4. The most outstanding success in the reduction of infant mortality has occurred in the period over one month and under one year of age. Here we can point with justifiable pride to our public health efforts which have resulted in an enormous gain in this

* Address before the general session of the National Organization for Public Health Nursing, Biennial Convention, Milwaukee, Wis., June 12, 1930.

period of life. There is no question but that better feeding methods, sanitary milk and water supplies, better heat hygiene, public health nursing, and more intelligent home care have been largely responsible for the reduction of infant mortality. While the reduction in this period has been considerable, there is still room for improvement, as a number of cities have reduced the rate to fifty per thousand live births and a few have actually reached the thirty mark. Some of the smaller western cities have been able to show a record of no deaths from gastro-intestinal diseases during the past year. If we are to reduce the infant mortality still further, the greatest efforts must be directed toward the neonatal period where the mortality remains relatively high.

5. The reduction of mortality over one year and under five years of age has been considerable also. While this period is not one of high mortality, it is characterized by damage to the child from infectious diseases, from malnutrition, and from accidents. The problem here is largely one of prevention of morbidity, although it is undoubtedly possible to reduce still further the mortality from a number of the infectious diseases and accidents.

6. The preschool period has come to be looked upon as the most strategic period in the child's life. It is not only a time in which the preservation of the child's physical health will reap the highest rewards, but it is also the golden period for mental hygiene. This is the period when decided social and personality adjustments are necessary. More and more attention is being centered here and it bids fair to command a greater share in the near future. While on the whole death rates among preschool children continue to decline, death rates due to accidents and certain communicable diseases remain high. Children are still entering school with a number of defects, physical, mental, and emotional, many of which could have been prevented by proper home and community hygiene.

WHAT TO DO ABOUT THESE PROBLEMS

The major problems, therefore, which we have to tackle are—how can we reduce maternal mortality and morbidity to a minimum and secure standards of safety for our mothers comparable to those in many foreign countries; how can we reduce the number of abortions and stillbirths and conserve the health of the mothers; what professional and public health means can be used to reduce the high death rate among the newborn; what can we do further to make infant mortality rates comparable to those in places where low figures have already been obtained; how can we reduce the risks to which the preschool child is exposed and prepare him for vigorous and normal school life?

It is my conviction that we already have at hand the necessary technics and scientific knowledge which, if applied rightly, and at the same time definitely to specific situations, would solve to a great degree the problems just enunciated. The difficulty arises in the application of these technics in the home, hospital, nursery school, kindergarten, and other organizations where children are brought together. It seems to me that today the greatest obstacles arise not in the lack of medical and nursing technics, nor in proper hospital or dispensary facilities, but in the absence of a well-organized community plan to meet the present day economic and educational stresses. We see the needs of both the poor and the economically well-off provided for now. Where specific technics for the reduction of maternal and infant mortality have been applied in these classes, considerable reduction in both morbidity and mortality has resulted. For evidence we turn to the epoch making work of the former Instructive District Nursing Association of Boston, of the Maternity Center Association of New York, and the Child Health Demonstrations under the American Red Cross and the Commonwealth Fund; also to

private philanthropy or official health work made possible for the poor and the well-to-do. Our great need now is to provide the same facilities for the masses of the middle class, those who are not able to pay full obstetric, hospital, and nursing fees. Furthermore, it is this class that is most in need of prenatal education that it may take advantage of community facilities and of proper hospital and medical care at rates within its reach.

THE STRATEGIC POSITION OF THE NURSE

I understand fully that the nurse has very little to do with determining economic, social, or industrial conditions, but she is in a position to view society broadly and to take her place in the scheme of things when a community organizes to make available better service. The nurse has definite relationships to the physician whether in private practice, hospital, or public health work. She is the ideal one to make contacts with the home and to follow up cases. She can get into touch with day nurseries, kindergartens, and nursery schools, and make her influence felt. To each of these organizations and professions the nurse must bear a definite and helpful relationship. The solution must await better community organization and the availability of funds.

In addition to her strictly technical services the nurse can be of assistance in dispelling superstitions and fears of the mother in preparing her mentally to approach the trying hour of confinement with confidence and equanimity. The results of such coöperation between physician, nurse, and prospective mother are well illustrated in case reports, as special features of prenatal work, where careful records have been kept. There can be no question that a well-planned prenatal service with thorough follow-up prepares the stage for a happy outcome to pregnancy. However, we must not suppose that prenatal care alone can accomplish everything and insure a safe result for both mother and child. The prenatal and postnatal services offered by several large insurance companies have amply demonstrated their value in saving mothers' lives, and there is undoubtedly a tendency to extend rather than limit this service. The experience of the insurance companies is that prenatal care brings returns in lowering the maternal mortality rate. But are these companies not approaching their limits with prenatal and postnatal care alone?

Prenatal care, however, no matter how high its quality, cannot atone for unskilled, hurried, or bungling obstetrics at the time of delivery. The final responsibility, therefore, for the safety of both mother and newborn, is largely in the hands of the obstetrician, although he can be assisted greatly by competent, skillful, nursing service. No physician should be expected to conduct a confinement without the help of a well-trained nurse. An extra pair of trained, clean hands is a distinct factor for safety during confinement. It is reasonably certain that, should every physician have the services of a well-trained nurse at the time of delivery, we would see a marked reduction in both the maternal and early infant deaths. I believe the time is approaching when the large insurance companies will accept the responsibility of extending obstetric nursing service to their industrial policy holders in addition to the prenatal and postnatal care which is now given. Unless mothers can be assured of skilled obstetric service and the additional protection which a trained nurse affords at the time of delivery, much of the effort expended in prenatal care will have been in vain.

HOSPITALIZATION OF MATERNITY CASES

The trend toward hospitalization of obstetric cases is certainly in the right direction. There is no question that the best equipped hospitals with capable visiting staff and proper nursing routines are the safest places where babies may be born, and we should encourage their use. On the other hand, mere hospitalization is no guarantee that all will go well. Experience has demonstrated that hospitals differ

in their ability to care for obstetric patients. The caliber of the medical staff and technics employed vary greatly. Many mothers would be better off in the hands of a careful conservative physician who has the assistance of a trained obstetric nurse in the home under modern circumstances, than in mediocre or poor hospitals. Studies carried out by the Buffalo Foundation indicate that maternal and infant mortality varies considerably in different hospitals and in the hands of different medical practitioners.

The care of the baby in its first days is of great importance. Here is where the nurse on duty in the hospital, or in private practice, can be of greatest assistance. The technic of breast feeding should be well understood by every nurse, and she should teach the mother to apply it conscientiously from the first. The baby should be handled with scrupulous care during its first hours, with no undue exposure and with no rough handling. Rough handling in order to establish respiration undoubtedly has been the cause of a number of unpleasant reactions. From the standpoint of mental hygiene, the nurse can help greatly from the earliest days, to establish proper habits of feeding, bathing, sleeping, etc. Fear, temper tantrums, and bad habits of various sorts are often begun early and are extremely difficult to break later on.

A growing field for the public health nurse lies in parental and preparental education. The well-trained nurse with a broad educational background is peculiarly fitted to assume responsibilities along this line. She should be prepared to give courses to the prospective mothers and to instruct young women in the secondary schools.

NEED OF BROADER TRAINING

Multiplied contacts and larger responsibilities of the public health nurse suggest that she must secure much broader and more generalized training in allied fields than has been offered her in the past. In dealing with the many community forces and with the technical professions, some knowledge of the background sciences used in common by these professions should be acquired by the public health nurse. It is important that she have a clear understanding of the structure of modern society and of the complex social and economic relations involved. Biology, as a fundamental science, is essential to the understanding of life processes, physiology, and hygiene. It is desirable that the nurse have some familiarity with vital statistics in order to be able to interpret trends, death rates, and other data involved in public health. Her contacts with preschool clinics, kindergartens, nursery schools, and the public schools make it almost imperative that the nurse gain a knowledge of the principles of psychology and especially the mental hygiene methods employed to meet the behavior difficulties of both children and adults. In other words, my plea is for broadly educated public health nurses, who will be able to take their stand beside the social worker, the teacher, the psychiatric worker, and others engaged in the educational process.

It is taken for granted that the public health nurse will have acquired certain technical skills from her preliminary hospital training and from the technics and routines which she has had to perform in her training as a public health nurse. In order to render the best community service, it is necessary for her to develop initiative, coöperative enterprise, and a social sense. She should build a sound basis of scientific content for health, which she will be able to impart in simple and attractive form to either the children or mothers who come under her care.

THE FUNCTION OF THE NURSE

As I see it, the problems connected with maternity and infancy will demand on the part of the nurse far more than mere technical training. In order to meet the major problems, the nurse will assume one or the other of the following functions:

An assistant and co-worker with the physician either in the home, the clinic, or the hospital, affording him an extra pair of trained hands and acting as his interpreter.

A health visitor, bringing her into intimate relations with the home as the interpreter of professional technics which may be suggested by the physician, the dentist, or the psychiatrist.

A health educator, who has acquired scientific information relating to health and is able to put this over to the child and the home in an effective manner. This will bring her directly in touch with the nursery school and kindergarten. She should be in a position to suggest content and methods of handling the children from a health point of view.

A health counsellor for the home and the school and in the various social organizations putting forth efforts for the health of mothers and children. The position of health counsellor or health correlator in secondary schools is opening up in a number of places and there is no reason why the nurse with good training and vision, as well as technical knowledge, should not occupy these positions.

An assistant in habit training work, collecting information from the homes and interpreting the findings of the clinics to the parents; also assisting in bringing about for the mental welfare of the mother and child.

The public health nurse of the future will become more and more a health educator and a home and school counsellor and less and less a "nurse" in the popularly accepted sense of that term.

Teaching Nutrition to the Prenatal Patient

By BLANCHE DIMOND
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THE first period of a baby's life, the nine months before he is born, has been called the most neglected period in relation to both care and feeding. This statement may still be true of many babies born in this country, but not for the babies whose mothers come under the care of nursing organizations with a well developed prenatal program.

The Community Health Association did pioneering work in this field, in 1901 assigning two nurses to obstetrical service. True, the conception of the necessary prenatal teaching was somewhat different then from what it is today, but it was at least a beginning. A report of the work reads: "If time affords when the nurse is not busy with confinement cases, she shall visit the patient before the expected arrival to teach her how to make the best use of the articles on hand and to have at least two sets of clothing ready." Due to the pressure of work "time seldom afforded" for these "preparatory visits" but by 1911 the policy of the association was to make three prenatal visits to each patient.

Since 1911 there has been a gradual change in the conception of the nurse's responsibility to the prenatal patient and consequently in the standards of prenatal care. That the quality of the work has improved is beyond question, and the following figures demonstrate the increase in case load: in 1912, 6,405 prenatal visits were made, about 6 per cent of the total, and in 1930, 32,049, or 9½ per cent of the total.

PRENATAL PROGRAM

The present prenatal program includes home visits and group teaching through Mothers' Clubs. At these Mothers' Clubs prospective mothers are taught by the nurse and nutritionist the fundamentals of prenatal care, preparation for delivery, the proper diet for themselves and their families, how to budget their incomes, and are also given two lessons on Mental Health by the Mental Health worker.

The patients are referred by private physicians, by social agencies, and routinely by the three hospitals having the largest prenatal registration. Normal cases are seen once a month for the first six months and twice a month during the last three months; abnormal cases are seen as often as necessary. In addition to these visits by the nurse,

the patient reports regularly to her own physician or hospital clinic.

On each visit urinalysis is done, the blood pressure taken, and a check-up made on the patient's physical condition, stressing the importance of medical supervision, preparation for delivery and the need for proper food and health habits.

Expectant mothers are given the following reasons for the need of prenatal care: pregnancy itself will be more comfortable; some of the difficulties of delivery may be eliminated, the baby may be more healthy because of her efforts, and his after-care made easier.

NUTRITION INSTRUCTION

It is with the food habits or nutrition of the patient that this paper is directly concerned. Nutrition is as important to the development of the child during the prenatal period as it is during the postnatal period. The baby can receive the proper elements for growth and life only through what his mother eats. The reason that some babies seem to suffer no ill effect when the diet is deficient during the prenatal period is that the baby acts to some extent as a parasite, and if there is not enough food for both, the mother suffers. A striking example of this is the woman on a calcium deficient diet whose teeth become carious during her child bearing period.

Almost without exception prenatal patients need dietary instruction. In this group even the most intelligent patient has little real knowledge of the food she should be eating. She may be having no milk because some one said "it would make her fat." She may be eating no raw vegetables because she never learned to like them as a child, or she may be eating meat twice a day.

There are many food prejudices among pregnant women. Many patients are sure that drinking milk makes them violently ill as it "poisons" them, but they can take it cooked in food. One woman said she could not eat an orange as "it lies right here," pointing to her stomach, but she could eat it in a salad or pudding. A soft cooked egg always distressed one of our patients, but she could eat it fried very hard. Another was told by a neighbor not to eat spinach as it would be bad for the baby. She was very fond of spinach but had heroically refrained from eating it. Many delight in telling of cravings for particular foods. This craving is usually for an especially expensive food or one hard to procure. Strawberries out of season and lobsters are two favorites. This is an excellent time for the nurse or nutritionist to show the need for a well balanced diet so that no cravings will occur.

Those women who are overweight or are gaining weight too rapidly are a group needing special instruction since most obstetricians are agreed that it is unwise for any pregnant woman to gain more than twenty-five pounds during the entire nine months and many prefer that the increase in weight shall be much less.

No diets are given without orders from a clinic or private physician. This rule has been in effect since nutrition work was begun and seems an excellent one to follow since it serves the three-fold purpose of giving us medical supervision for our work, of convincing the physician that we do not intend to over-step our bounds, and of letting him know that the service is available if he cares to use it.

PLAN OF WORK

When the nutrition work was first organized, all the clinics and many private physicians were visited, the service explained and special diets which had been worked out were offered for their approval. As a result all the clinics and many of the private physicians gave standing orders to have diets outlined for their patients. If the doctor has not given these orders the nurse or nutritionist always calls him for permission and instruction before giving any advice. If the permission is not given, no advice is given the patient.

Patients are taught first the proper prenatal diet, which, after all, is only

the optimal, daily, family diet. This is explained very simply to our mothers as "the six essentials." After one or two visits at Mothers' Clubs any patient when asked, "What are the six essentials?" will answer quickly, "one quart of milk, a citrus fruit, two vegetables, one raw and one cooked, a whole grain cereal or bread and unless the doctor forbids it, an egg." They are also taught the correct diet for the various conditions frequently arising in pregnancy—heartburn, nausea, and the diet in toxemia.

Many women also need help in planning a daily schedule of work so adjusted that the new baby and its care fits into the day's work without discouraging the mother. Another large group need instruction in budgeting their income so as to cover the necessarily increased expenses due to the baby.

PRACTICAL AND EFFECTIVE TEACHING

To be effective, nutrition teaching must appeal to both the intellect and emotion of the patient. These women are eager to know the right thing to do, but they must be convinced that it is right before they are willing to change the habits of a life time. Reasons must be definite and specific. A simple explanation of the mechanism of digestion makes the importance of eating bulky foods to relieve constipation much easier to understand. A picture is a very telling teaching device. Pictures of the stomach and intestines under different conditions succeeded in convincing a number of women that they should eat more coarse foods. Photographs of children with good and poor teeth with the description of the prenatal diet of these children's mothers persuaded many patients to take milk. When a patient realizes why eating meat twice a day is harmful for her, she will be much more likely stop the practice. Some one has said that the reason we are more concerned with our clothes than our food is that we can see what our clothes do to us but we cannot see what our food does to us. We must make our patients realize the importance of the right food.

Getting a patient to keep a record of her food intake for a week and discussing it with her on a subsequent visit helps to change poor food habits. She is anxious to have a good record to show the nurse or nutritionist and the fact that she writes the meals on paper three times a day makes her more "nutrition conscious."

Suggestions for taking food in different forms are frequently given. Recipes for cooking with milk are very helpful for the person who dislikes milk. Some women who cannot tolerate sweet milk may be willing to take buttermilk. Patients are urged to use at least a part of their milk in their cooking. If eggs cannot be eaten plain, they can often be used in a pudding or a salad.

The appeal to the emotions is usually effective. If the mother can be made to visualize a living being whose body she is building by the food she is eating, the task will be quite simple. We may say something like this: "If this baby were toddling about your feet now where you could see him, there is nothing you wouldn't do for him. It is doubly important that you do the right thing for him now when he is entirely dependent on you for giving him a fine healthy body." That appeal seldom fails. She will eat cabbage, oranges, or anything else you may advise. If milk makes good teeth for the baby, of course she will take it though she despises it. Many times both fathers and mothers have changed their food habits so that their baby will have a good example when it is time for him to eat the vegetables and other foods he should have. This emotional appeal is most effective when the mother is having her first baby as both parents are so ready at that time to learn and to do everything they can to give the baby the right start in life.

The Mothers' Clubs are valuable in interesting the women in good, general nutrition. Talks given by nutritionists not only consider the normal prenatal diet with the necessary variations for

abnormalities but also the importance of the daily schedule for work and living on a budget. One of the most popular talks is on the budget. It is always surprising that the women will so frankly discuss their husbands' wages and their weekly expenses before other women. Usually a budget for one of the class members is worked out on the blackboard while all look on, give suggestions and discuss their common problems.

The refreshments served at the Club are all planned with a view to improving the food habits of the women. It is much easier to be convinced that a new food is good if one has tasted it and been shown how to prepare it. No better proof of this is needed than the fact that the morning after Mothers' Club one of our nutritionists found four women making the corn and tomato chowder which had been demonstrated at the Club the previous day. Well balanced meals are set up with food models. Posters are used with every talk.

RESULTS OF NUTRITION TEACHING

This nutrition teaching has had certain definite results. First the interest of the prenatal patient in her diet is transferred to planning well balanced meals for her family. She tries to change their food habits since she now realizes that "the six essentials" with minor modifications are necessary for good nutrition in all age groups.

Echoes of the teaching are heard in the neighborhood for a long time. Two years after Mrs. A., an especially grateful patient, had been discharged another woman came to the Mothers' Club to refer herself as a patient because she had heard such glowing reports of the club from Mrs. A., her neighbor, and was looking forward to the same good results which Mrs. A. had experienced.

Teaching which fails on a first occasion may be surprisingly successful the second time. One of our patients, a very obese woman, was put on a weight reduction diet which she did not follow. She lost her baby. When she became pregnant the second time she reported immediately to clinic, asked to be put on a weight reduction diet which she followed faithfully with excellent results. She had an easy delivery and a fine healthy baby. She was very grateful and told all her friends how much they could learn from the talks at Mothers' Clubs.

Another pleasing result is the interest aroused in the father. In one of the foreign districts the nutritionist called on a patient, found her absent and left a note telling her she would come the following day. The next morning the woman's husband appeared at the office to find out what it was all about. After the purpose of the visit was explained to him, he promised that his wife would be at home. While the nutritionist made the visit, the woman wrote down everything she said because "my husband told me to so he can see if I eat what I should." Another illustration of the father's interest is the Italian laborer who came to Mothers' Club, clutching the postcard which had been sent his wife inviting her to come to the club. "She no spik English, so I come," he stated to the nurses.

The results of weight reduction are interesting. Individual cases have been carried with successful results, but the most striking demonstration has been worked out in one of the maternity homes in Boston. A nutritionist goes there weekly to talk to the prospective mothers on food and health habits. None of the girls is allowed to gain more than twenty-five pounds during the nine months of pregnancy. Many of them came to the home in a very undernourished condition due either to poor food habits or to eating too little food in an attempt to keep their weight down and conceal their condition. Under the regime of regular hours and good food they put on weight rapidly. They are divided into three groups—those who need reduction, those needing to gain weight, and those whose weight should remain constant. The results have been most encouraging. The food habits have improved remarkably, the overweights have re-

duced and the underweights have gained.

That this teaching must be constantly carried on is well demonstrated by the fact that in the absence of the nutritionist the interest of the whole class slumped, dietary instruction was incompletely carried out, and as a result the weight tables showed undesirable variations.

These and many less tangible results lead to the conclusion that teaching nutrition to the pregnant woman is distinctly worth while.

SHOULD WE SAY "VENEREAL" DISEASE?

"*Venereal diseases* (from 'venery,' *i.e.*, the pursuit of Venus, the goddess of love), a general term for the diseases resulting from impure sexual intercourse. Three distinct affections are included under this term—gonorrhea, local contagious ulcers, known as chancres, and syphilis. At one time these were regarded as different forms of the same disease. They are, however, three distinct diseases, due to separate causes, and have nothing in common except their habitat."—Encyclopaedia Britannica, 14th Edition, page 42.

The name "venereal disease" is employed as an inclusive term for (1) a simple local infection — chancroid; (2) an infection that usually remains local and which is rarely fatal—gonorrhea; and (3) a grave systemic disease which is one of the principal causes of death—syphilis. The causal organisms, the clinical manifestations and complications and the gravity of these diseases are entirely dissimilar, yet we lump them together as "venereal diseases."

Scarlet fever acquired from a prostitute is not called a "venereal" disease, but gonorrhea acquired by a woman from her lawful husband is called a "venereal" disease. The inclusive term "venereal diseases" is based on the fact that one of the common sources of infection is venial sexual contact. The medical profession, public health workers and nurses understand that syphilis and gonorrhea are not always "venereal"; the layman does not. To him syphilis and gonorrhea are the "diseases of vice," the "wages of sin." If syphilis and gonorrhea are the wages of sin, many women and children and some men are collecting wages which do not belong to them. A large percentage of cases of syphilis and gonorrhea are quite unassociated with sexual immorality, on the part of the sufferers as shown by the following:

I. Non-"venereal" syphilis.
   1. Congenital syphilis (all).
   2. Familial syphilis, whether of children or of either spouse (a large part).
   3. Extra-genital syphilis (a large part).

II. Non-"venereal" gonorrhea.
   1. Ophthalmia neonatorum (all).
   2. Infantile cervico-vaginitis (all).
   3. Familial gonorrhea, whether of children or either spouse (a large part).
   4. Eye infections in adults (a large part).

Is it sound in medical and public health work, to refer to syphilis and gonorrhea under the blanket term "venereal diseases"? Does the stigma of the word "venereal" help us to combat these infections? Would we not be more accurate, as well as more just and considerate, if we called these diseases by their proper scientific names, syphilis, gonorrhea, chancroid, in our writings, publications, and speeches?

—Walter Clarke, M.D., Director Division of Medical Measures, American Social Hygiene Association.

A New Approach to Social Hygiene through Public Health Nursing *

By Edna L. Moore
Assistant Director, National Organization for Public Health Nursing

IN the United States the term Social Hygiene means something quite different from what is understood by it in Europe. Here, the term is used in a derived rather than a literal sense. A definition found in the literature of the American Social Hygiene Association will be helpful to the reader. It is: "Social Hygiene includes those social health problems which, directly or indirectly, have grown out of the sex instinct." The problems of concern to public health nurses have to do with all that relates to the control and prevention of the two communicable diseases, syphilis and gonorrhea, and the health education this involves.

During, and immediately following the Great War, social hygiene activities were, to a large extent, reformatory in character. This phase is passing rapidly, although many health workers apparently have not realized it. Today the trend is toward giving social hygiene an established place in every well developed community health and social program and therefore it is inherent in the responsibility of the doctor, nurse, and social worker.

Since 1914 the American Social Hygiene Association has done pioneer work in a relatively unpopular field. Today the results of its efforts are to be seen in the educational, legal and protective, medical and public health fields. The members of the Association in annual meeting, January, 1929, adopted unanimously the following resolution:

Whereas, Congenital syphilis is one of the most frequent causes of foetal and neo-natal deaths, and one of the greatest mental and physical disasters among those who survive and—

Whereas, There are medical procedures which, when properly applied to the pregnant syphilitic woman, will almost certainly prevent congenital syphilis in the child, be it therefore—

Resolved, That the American Social Hygiene Association advocates the adoption of vigorous measures for the prevention of congenital syphilis, and especially directs its officers to promote the spread of information to the public regarding the great advantage of medical supervision early in pregnancy; to secure the coöperation of nursing, public health and social groups with the medical profession in securing adequate treatment of every pregnant woman, thereby preventing congenital syphilis; and in particular, to encourage those in charge of prenatal clinics to devote attention to the discovery and treatment of syphilis among all women who are in attendance.

Accordingly, a joint arrangement with the National Organization for Public Health Nursing readily suggested itself to those charged with carrying out the spirit of this resolution. This resulted in a definite project which was initiated in October, 1929.

THE NATIONAL PROGRAM

A staff member of the National Organization for Public Health Nursing was assigned to develop a program with the assistance of an advisory committee appointed by both the sponsoring associations. This committee numbers among its members a professor of biology, who is also Director of the School of Practical Arts, Teachers College, Columbia University, a physician, a public spirited non-professional woman, four public health nurses representing different types of organizations as well as varied fields of work. The chairman is the director of a large and forward-looking community health organization.**

The advantages of the staff arrange-

* Reprinted through the courtesy of the editor of *The International Nursing Review.*
** The personnel of this committee is listed on page 593 of the November number of this magazine.

ment are numerous. Seemingly the most important are these:

The social hygiene worker is kept in touch with activities in every phase of public health nursing.

The same general policies maintain, thus preventing confusion in the field.

The service and standard-making organization, whose membership is largely made up of public health nurses scattered throughout the country, is the logical center to which they turn for advice and help.

The pages of the organization's magazine, THE PUBLIC HEALTH NURSE, are open to carry information regarding the project to public health nurses, health officials and board members.

The offices of the coöperating organizations are in the same building and on the same floor. The benefits from this proximity are easily understood.

The object of the social hygiene nursing project may be stated briefly as follows: To make social hygiene a conscious part of every public health nursing program and to help nurses to meet the special problems involved.

As stated previously, the trend is out of the realm of reform. It is important that the significance of this should be understood. A variety of problems will confront the public health nurse in this field, yet, all of them will fall into one or the other of the two groups before mentioned: health education, and the prevention and control of communicable diseases. These questions of social hygiene are essentially health questions and if success is to be attained they must be approached by the nurse as such. Any stigmatization of the diseased individual for presumed moral lapses may endanger the primary interest. To deal with these health questions necessitates a knowledge of the so-called venereal diseases, as well as a broad understanding of the place of sex in human life.

In studying the situation with respect to these requisites it is disquieting to find that both phases have been omitted in the preparation of most nurses in the country today. Nevertheless, this is a fact, and we must face the problem of supplying the need and, in some instances, creating the urge to see it as a necessary acquisition. Education is fundamental. We are confronted at our next step with the practical questions: What education is needed, and how shall it be offered? Before either can be answered we must know more of conditions as they exist.

With these things before it the Joint Advisory Committee, at its first meeting, authorized the following fact-finding activities: a limited use of the questionnaire, a study of reports from recognized sources and field observations. The first and second offered means for explaining the project, while the third presented excellent opportunities to discuss the practical application of the objectives.

Contacts in the field have been through state and local departments of health; State and local public health nursing organizations; State graduate nurses' associations; State, regional, and local social hygiene associations, and local departments of education. Letters announcing the project and some tentative plans were sent to state departments of health throughout the country. In every instance the fullest coöperation has been received.

It is hoped that several local demonstrations may be developed in order that different methods of procedure may be tested. This, or some other means of reducing the focus of the plan, is necessary before standards can be evolved.

Since emphasis is placed upon the prevention of congenital syphilis the work of prenatal clinics is being studied. Routine tests to determine the presence of syphilis are made in many of them, but, all too often, the arrangements for treatment are so cumbersome that comparatively few women attend long enough to accomplish the desired results. However, conditions in general are improving steadily.

Excellent opportunities for group teaching offer themselves at prenatal clinics. The hygiene of pregnancy presents special problems that cannot be dealt with adequately unless the field of social hygiene is touched upon. Group discussion with the mothers can clear away misunderstanding and

superstition, and help them to interpret the facts of life to their children. Many difficulties that have a direct or indirect relationship to sex come to the attention of the nurses who are trained to recognize them. Moreover, people expect a nurse to be able to explain and advise about everything that relates to human physical life; and to fail in one particular will lessen her influence in another.

Public health nurses in every country are faced with the troubles that accompany ophthalmia neonatorum, cervico-vaginitis, and congenital syphilis in its various guises. In the absence of standardized procedures, we may follow with profit to the individual and the community those techniques that are used in tuberculosis nursing. All contacts should be examined and persistent efforts made to find sources of infection. Treatment must continue over a protracted period during which hope and courage are apt to wane unless constantly renewed. Symptoms may disappear and give to the uninstructed a delusion of cure. Economic stresses may come and domestic ties grow strained. At all times the family unit must be kept in mind. How all these problems are handled matters seriously to the community. They are health questions and fall within the purview of the public health worker.

Short courses of lectures, and the presentation of scientific material through films, offer means of carrying the latent information to the nurses in the field. Plans have been made to give such service in the form of institutes covering two or three days. A carefully selected bibliography has been prepared for distribution.* Through other channels efforts are being made to include such additional subject matter as seems necessary in the existing courses of the schools of nursing.

In the development of a project with so many unknowns the trial and error method is the only one to follow. It makes for an open mind and a sense of adventure on the part of those participating. And why not adventure? Are not many to profit by the results which, it is hoped, will chart a way by which many may be helped toward fullness of life as well as length of days.

* See THE PUBLIC HEALTH NURSE for October, 1930. Also available in reprint form.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR DECEMBER, 1930

Christmas in Hospital	
In an English Hospital	Hester Viney, S.R.N.
In a Southern Hospital	Mrs. Robert Jolly.
In a Philadelphia General Hospital.	
In Denmark	Charlotte Munk, R.N.
Pernicious Anemia	James Bordley III, M.D.
Recipes for Use of Liver	Bertha M. Wood, R.N.
Nursing Costs	Phoebe Gordon
The Nurse's Responsibility in Diphtheria	Virginia Boyer Miller, R.N.
Nutrition and the Health Program	Sister Gonzaga, R.N.
Parliamentary Procedure and Public Speaking	Helena Zachos
Home Nursing in Pneumonia	Vesta Faulkner, R.N.
Nursing Speaks	V. McCormick.
A Practical Ice Cap Cover	Marie Villing, R.N.
Nursing Medical Patients	
Problems with Neurological Patients	Florence K. Wilson, R.N.
Nursing in Syria	Sarah G. Shahla
Student Health	H. W. Munson
Grading: Costs of Education	M. A. Burgess, Ph.D.
The Teaching of Prevention	Annie W. Goodrich, R.N.
Case Records	H. W. Munson

Observations on Reactions of Infants with Reference to Beginnings of Health Behavior

By Johanna Eggers

Director of Prenatal and Maternity Service, University of Oregon Medical School

Editorial Note: While the findings from this study of thirty-three infants are not new nor revolutionary, nor compiled to prove any one scientific fact, we are offering them to our readers to show what kind of a contribution might be made to the science and art of nursing from the wealth of material lying at the hands of public health nurses during home visits. The study serves to show how one nurse approached her patients from the student point of view, and incidentally tested to her own satisfaction, from her own observation and notes, the information gained from textbooks. It is one thing to read that the night feeding may be omitted within a few weeks of birth, another to train thirty-three mothers to omit it, and prove to their satisfaction and your own that the infant is the better for it.

The conclusions presented here represent only a partial list of those in the original study.

THE conclusions given in this article were drawn from a study made on infants, whose ages ranged from birth to twenty months. The study was made while on duty at the Maternity Center Association, New York City, and was submitted and accepted as a thesis for the degree of Master of Arts, in the Faculty of Practical Arts, Department of Health Education, Columbia University, June, 1929.

The purpose of the study was to observe the manifestations, responses, and reflexes in early infancy, as these appeared to be related to health behavior. The hypothesis was that these early manifestations might serve as an indication of how health habits are formed, and therefore offer guidance in initiating health education.

The data presented are based on conditions observed in the homes and recorded in running diary form. Thirty-three infants were studied. After the observations were completed, the findings were compiled, and from these, general and specific conclusions were drawn.

CONCLUSIONS

Physiological manifestations as related to health behavior:

The feeding of infants was regulated at an early age, and nursing at regular intervals established a few days after birth. Infants were trained to omit one night feeding a few weeks after birth; that is to say that they slept at longer intervals at night when properly trained, so that the night feedings were reduced by at least one feeding. Breast milk proved to be the ideal food for most of the infants. Breast fed infants had few gastro-intestinal disturbances if nursed regularly, and they gained at a normal rate.

Infants were trained to drink fresh sterile water from birth. If it is difficult to give water by bottle it may be given by a spoon. Repeated efforts to offer water usually conquered any obstinacy.

Satisfactory reactions to cleanliness, warmth, and dry clothing were detected at any early age. Every infant enjoyed the tub bath, and demanded it by manifestations of fretfulness at the accustomed time, if it was not given. To have the head massaged with soap and then washed was enjoyed, but to have the face washed was disliked.

Every infant reacted favorably to warmth; sleeping well when warm, content when bathed in a warm room, and while lying awake in cribs. Many infants were found to be fretful when wet or soiled, and all infants observed at birth cried or fretted until the vernix caseosa was removed. Whether this was a response to being cold, unclean, or to some other factor could not be determined. However, the babies were well wrapped and kept warm before cleansing took place; therefore, it would seem that they actually were uncomfortable on account of not being clean.

Training infants to use the commode

for elimination may be begun as soon as the cord is healed. The infant must be observed as to the time he eliminates, then placed on a *comfortable* commode, in a comfortable position and soon he reacts to this procedure. The time to place infants on a commode is at awakening and after feeding. It is easier to train infants for defecations than for urinations. The former was accomplished within a few days in all cases where the mother made a real effort. The latter was accomplished within several months.

The hours of sleep were regulated at an early age. A young infant will sleep from eighteen to twenty hours out of the twenty-four, if kept in a well-ventilated room, in a comfortable crib, comfortably dressed, clean, warm and well nourished.

Favorable reactions to fresh air were secured at an early age. Fresh air was found to be beneficial to all infants as soon as the mothers were able to take them out-of-doors. They went to sleep or were quiet while out-of-doors, and slept better at night. They cried less.

Responses and reflexes as related to health behavior:

Responses in the infant were detected shortly after birth. This agrees with the experiments of J. B. Watson and other scientists.* Responses of rage were observed when the child's movements were hampered and he struggled and cried when tied in a hammock for weighing. Kant writes, "The cry of a child just at birth has not the tone of lamentation, but of aroused wrath." This cry is probably due in part to the immediate hampering of movements which invariably takes place. Infants objected to having their clothing removed, apparently through fear of loss of support. They grasped and clutched any object near them when being undressed.

At seven weeks an infant was noticed to distinguish its parents from strangers. Infants responded to attention a few weeks after birth. They smiled when caressed and spoken to, showed desire to be taken up, if this had been done a great deal. Infants may be conditioned so that they desire to be taken up. An infant sixteen days old, came home from the hospital and within six days, although not accustomed to being taken up at the time she came home, showed definite symptoms of resentment when placed in her crib, and would quiet immediately when taken up. An infant a few days old had been allowed to sleep with a light at night. She would cry as soon as the light was extinguished. Temper tantrums were noticed as early as the thirty-sixth and thirty-eighth days. These were apparently due to too much previous attention,** or may have been fatigue resulting from the change from a quiet to a noisy environment.

Equally well, therefore, infants can be conditioned to sleeping alone shortly after birth. It was found that, if mothers kept their babes in bed with them until they recovered from their lying-in period, it was rather difficult to recondition them to sleeping alone.

The Babinski reflex was noticed to be present in all infants observed. Infants were sensitive to having their nostrils cleansed with a cotton swab and oil, but were not sensitive to this procedure when applied to their ears. Touching the mucous membranes, or perhaps partial air obstruction caused them to draw their heads back and to knit their brows. Infants from birth reacted to a bright light, they squinted immediately.

All infants observed at birth reacted to shading of the eyes. They opened them without fail. This is significant in the treatment of the eyes of the newborn, as much manipulation of the eyes may be avoided by simply shading the eyes with one hand. The eyes are sensitive to pain at birth. There was crying and squinting following the

* Watson, J. B. Psychological Care of Infant and Child. W. W. Norton and Company, Inc., New York, 1928.

** Blanton, S., and Blanton, M. Child Guidance. Century Co., 1924.

application of silver nitrate in the eyes, yet crying did not follow any washing of eyes with boracic solution, which followed the silver nitrate treatments.

Infants may give a clue to pain areas. One infant developed otitis media; she was crying a great deal and hitting her ear frequently.

How infants reacted to attitudes of parents and environment:

The majority of the parents in the study adjusted to the proper care of their infants by taking them out-of-doors, giving daily baths at regular hours, keeping them clean, having comfortable clothing for them, feeding at regular intervals, ventilating and heating their apartments properly. The fathers, as a rule, considered the health of the mothers for the welfare of the infants, did not expect them to assist in supporting the family, and were usually devoted to their offspring.

Infants proved to be indirectly very sensitive to the attitudes of their parents; for instance, if the father were unemployed, the mother worried, lost her breast milk, and the infant lost weight and cried. If the father were sick and ill disposed, the mother trying to care for him, she in turn worried and was depressed, and a fretful infant resulted.

Economic conditions affected infants, in that if the home were cold, the infant cried; if clothing and bedding were insufficient, the infant cried; and if the mother failed to get sufficient and proper food, her breast milk grew scanty and of poor quality, which resulted in the infant losing weight and crying.

The study suggested a standard of manifestations and reactions for normal infants six weeks old in relation to health behavior, and provided a few sound principles of health education for the normal infant. At six weeks normal infants should:

Be trained to feed regularly at three or four hour intervals, omitting a night feeding.
Have acquired an appetite for fresh water.
Be quiet and content if left alone and warm in their cribs.
Use the commode for elimination—entirely for defecation, partially for urination.
Demand cleanliness by crying or fretting, by restless movements, or by some other complaining reactions (not always true).
Enjoy a tub bath and demand it at a definite time.
Have a temperature by rectum of 97 to 99.4° F.
Sleep about eighteen to twenty hours in twenty-four.
Gain from four to twelve ounces a week. (A longitudinal gain is significant.)
React favorably to fresh air in-doors and out-of-doors.
Demand by manifestations to sleep in their own beds.
React favorably to loose, comfortable clothing.

Out of these simple basic health regulations, imposed on the nervous system in early infancy, should grow *self-control,* which is the foundation of proper health control.

Courtesy of Henry Street Visiting Nurse Service

Nurses in Commerce and Industry

By Louise M. Tattershall
Statistician, National Organization for Public Health Nursing

Continued from November

WRITTEN STANDING ORDERS

Closely connected with the question of professional responsibility is that of whether she has "written standing orders." Does the nurse have orders for treatments and medications from a physician or group of physicians which are to be used when no physician is present or until a physician can be secured?

Only in 315 establishments, or in less than one-third of the total number reporting, does the nurse have written standing orders. In 308 of these, physicians are employed. The nurses employed in these establishments represent 32 per cent of all the nurses included in the report.

The per cent of total establishments where the nurse has written standing orders does not vary much in the different kinds of industries reporting, or in establishments of different number of employees. In 12 of the 24 different types of industries reporting, the per cent ranges from 27 to 34, and the range for establishments of different sizes is from 23 to 36.

WHERE THE NURSE SPENDS HER TIME

One of the purposes of this study, perhaps the main one, was to get some idea as to the services that a nurse in industry is asked to give. The first point to be considered in getting such a picture is to find out where the nurse gives her services: Is all her time spent inside the establishment, or is it spent outside in visits to homes, or is her time divided?

In 466 establishments or 46 per cent of the total number, nurses are employed for work inside the establishment only.* In 529 establishments, or 52 per cent, nurses are employed both for work inside the establishment and for visiting in the homes. In 11 establishments, or in 1 per cent, nurses are employed for outside visiting only. Seven of these 11 establishments belong to the textiles industries and 2 to the mining industry.

While the nurses in 529 establishments have some contact with the homes of employees, the nature of this contact is not the same in all cases. In 164 establishments the nurse visits the home for the purpose of following up absentee employees only. In the remaining 365 establishments the nurse gives nursing care or health instruction in the homes of employees.

Considering the establishments, classified by size, we find that establishments having between 500 to 10,000 employees are about equally divided as to whether the nurse is employed entirely for inside work, or gives part time to inside work and part time to home visiting. Turning to establishments with less than 500, and those with 10,000 or more employees, we find approximately two-thirds of them report that nurses are employed for both inside work and outside visiting. In establishments classified by type of industry, we find a group of 8 industries: banks, insurance companies, mining companies, tobacco manufacturers, miscellaneous industries, mercantile establishments, telephone and telegraph companies, light, heat and power companies, where, in two-thirds of the number of establishments of each industry, nurses are employed for both inside work and outside visiting. In another group of 6 industries—hotels, iron and steel and their products, rubber products, stone, clay and glass products, musical instruments, transportation equipment, we find, in two-thirds of the establish-

* Given in Tables 12 and 13.

ments of each industry—nurses do inside work only.

In establishments where nurses do both inside work and outside visiting, the same nurses may carry both services, or the staff be divided between inside and outside work. Of the total 2,022 nurses included in the report, 1,250, or 62 per cent, are employed for inside work only. The 180 men and 1,070 women, making up the 1,250 nurses, represent 95 per cent of the male nurses and 58 per cent of the female nurses. Two hundred and nine nurses, or 10 per cent of the total, do outside visiting only, and 563, or 28 per cent, do both inside work and outside visiting.*

CONTENT OF NURSING SERVICE

The information gathered as to the services expected of a nurse employed in a commercial or industrial concern has to do with the general nature of the services performed and not with any of the detailed duties. The services given by nurses have been classified under three headings:

Services in the establishment
Services in the home
Other services

Under the first two headings are included those services which a nurse, in her professional capacity, might be expected to perform, such as emergency treatments of injuries and of sickness, health instructions to employees, or nursing care in the homes. Under the third heading, "Other Services" is included work which a nurse may do, but which is not of a nursing character.**

As would be expected, the services which industrial nurses perform relate most frequently to first aid, as in all but 15 or in 980 establishments nurses give emergency treatments for injuries and in 955 of these take care of sickness as well. In 848 establishments subsequent treatments of injuries or sickness are also given. In one of these, this subsequent treatment is not given in addition to emergency treatments. So in 847 or 85 per cent of the establishments the services of the nurse include emergency treatments of injuries and sickness, and subsequent treatments of these.

Other services rendered by nurses are listed below.***

The number of different services that a nurse may perform in a single establishment ranges from 1 to the 8 services listed in the tables. The number of services which may be given and the number of establishments reporting are as follows:

No. of different services given	Number of establishments reporting
1	33
2	131
3	200
4	212
5	218
6	124
7	63
8	14

Where only one service is given it will be emergency treatment of injuries and sickness.†

The most frequent service that nurses are asked to perform outside the establishment is visiting in the home for the purpose of absentee follow-up. In 516 or 96 per cent of the 540 establishments, where the nurse has some contact with employees in their homes,

* Tables 14 and 15 give the total number of nurses employed in these three capacities.

** Tables 16 and 17 give the services a nurse may perform in an establishment, and the number of establishments reporting; tables 18 and 19, the services performed in the homes, the number of establishments reporting; and tables 20 and 21, the other services performed and the number of establishments reporting.

*** Assisting the doctor in physical examinations..... 58% of the establishments
Health instructions to employees..... 51% " "
Participation in Safety Program..... 50% " "
Sanitary inspection of plant..... 36% " "
Nurse's examinations (inspection) of employees..... 26% " "
Assisting the dentist..... 7% " "

† What the combination of services will be, where more than one service is given can be seen from the complete tables.

this contact is through routine visiting of absentee employees. In 74 per cent of these establishments only such employees as are known or suspected to be sick are visited, and in the remaining 26 per cent all absentee employees are visited.

In 340 establishments, or 63 per cent of the establishments where the nurse has some contact with the homes, nursing care is given to either employees or to employees and their families. The number of establishments providing care for employees' families is smaller than the number providing nursing care for employees only.

A third service given by nurses in the homes, is health instruction to employees' families. One hundred and ninety-eight establishments, or 37 per cent of the establishments having some contact with the homes, provide this service.

Considering the different services or combinations of services that a nurse may give in the home

1 establishment provides only health instruction to employees' families.
4 establishments provide nursing care to employees or to employees and their families.
164 establishments provide routine visiting of absentee employees.
19 establishments provide nursing care to employees or employees and their families and health instruction to employees' families.
35 establishments provide routine visiting of absentee employees and health instruction to employees' families.

The services rendered in the home do not seem to be dependent on the type of industry or the size of the establishment, as there is little variation in the services rendered in the homes by the different types or sizes of establishments reporting.

In addition to services of a professional nature, nurses in 671 establishments were engaged in other types of work. Little information, if any, is given as to the kind of work done, although this was requested. The only statement which can be made, therefore, is that the nurse had something to do with other types of work. Workmen's Compensation and clerical work are the types of non-professional duties done in the greatest number of establishments.

WORKING HOURS OF NURSES

The daily working hours of nurses were reported and from these the number of working hours in a week has been computed. In 927 establishments the median number of working hours in a week for nurses is 48.8 hours. Weekly working hours of from 44 to 52 hours are reported for more than 50 per cent of the total number of establishments and also for each group of industries, classified by type, with one exception, and for each group classified by size of establishment as well. Insurance companies are the exception where in more than 50 per cent of the establishments the weekly working hours are less than 44 hours. The fewest number of hours reported by any establishment is a working week of 35 hours, and the greatest, a 60 hour working week.

The working hours for nurses in industry are longer than those of nurses employed by public health nursing associations. Studies made by the National Organization for Public Health Nursing give the following median number of working hours in a week for these agencies:

Health Departments	44.7 hours
Boards of Education	39.7 hours
Public Health Nursing Ass'ns	47.3 hours

Information was given for 443 establishments,* as to the time nurses begin work in the morning and the time they stop work in the afternoon: 8 A.M. is the most usual hour to begin work, and 5 P.M. for stopping work.

The hours for insurance companies and mercantile establishments are exceptions. The time to begin work for these industries is 8:30 or 9:00 o'clock and the time for stopping work in insurance companies is 4:30 o'clock and for mercantile establishments 5:30 o'clock.

In 156 establishments, nurses are re-

* Tables 24, 25.

ported to work a full day on Saturday. These establishments are in the following industries:

Industry	Number of establishments reporting
Mining	4
Hotels	1
Food and kindred products	4
Textiles and their products	4
Iron and steel and their products	21
Paper, printing and related industries	10
Chemicals and allied products	7
Stone, clay, and glass products	10
Machinery, not including transportation equipment	7
Transportation equipment	2
Mercantile establishments	81
Miscellaneous companies	5

In only two establishments, one a mining industry and the other an iron and steel industry, are nurses reported to work on Sunday.*

* Tables 29 and 30.

FINDINGS

Certain facts as to the study as a whole stand out:*

1. The employment of nurses in industrial and commercial concerns is not confined to any one type of industry or to establishments having a certain number of employees. One thousand six establishments report that nurses are employed to look after the welfare of their employees. This 1,006 includes establishments from 24 different types of industrial and commercial concerns with the number of employees in the establishments ranging from less than 250 to more than 10,000.

2. The nurse employed is in most instances a female registered nurse. Of the total 2,022 nurses reported as being employed by the various establishments only 189 or 9 per cent are men. Eighty-five per cent of the total number of nurses employed are registered nurses. However, only 26 per cent of the men are registered nurses, so that where a man is employed as a nurse, he is likely to be a practical nurse.

3. The employment of men as nurses is confined largely to industries where the work is of a heavy nature and where there are few, if any female employees, as in the iron and steel industries.

4. The employment of practical nurses only is found in but 5 per cent of the establishments reporting. These establishments are not confined to particular types of industries, but the majority of establishments, where they are employed, have less than 1,000 employees.

5. The nurses are practically all employed full time for nursing services, only 4 per cent of the total number of nurses being employed part time.

6. Physicians are employed in some capacity, full time, part time, or on call, in 91 per cent of the establishments. Physicians employed for full time duty tend to be employed in establishments having 2,000 or more employees, while physicians on call are found more often in establishments with less than 1,000 employees. There are more establishments having physicians for part time than there are establishments having physicians for full time, or having physicians on call only.

7. More than three-fourths of the nurses, employed in more than half of the establishments are professionally responsible to a physician. The question of responsibility to a physician is not a matter of whether a physician is employed or not, as physicians are employed in more than three-fourths of the establishments where the nurse is professionally responsible to some one other than a physician.

8. Less than one-third of the establishments report that their nurses have written standing orders.

9. A little more than half of the establishments employ nurses for work inside the establishment and for outside visiting in the homes.

10. Three-fifths of all the nurses are employed in the establishment for inside work only. This number includes almost all the male nurses and more than half the female nurses.

* There has been no attempt to write a complete discussion of all the information given in the various tables and many more facts relating to particular types of industries and to establishments of particular number of employees may be brought out by a study of the tables.

11. Of the different services which nurses perform within the establishment, emergency treatment of injuries and sickness is the one that is found in practically all establishments and when the nurse gives only one service, this will be the one given.

12. In addition to emergency treatment, nurses give subsequent treatments of injuries or sickness in all but about 4 per cent of the establishments.

13. Nurses may give the following services, listed in descending order of frequency with which they are given:

1. Assisting the doctor in physical examinations
2. Health instruction to employees
3. Participation in Safety Program
4. Sanitary inspection of plant
5. Nurse examination (inspection) of employees
6. Assisting the dentist

14. Routine visiting of absentee employees, either all absentees or those known or suspected to be sick, is the most usual service rendered in the homes. Visiting of absentee employees known or suspected to be sick is done more often than the visiting of all absentee employees.

15. Nursing care to employees or employees and their families is given by nurses in a little more than three-fifths of establishments reporting outside visiting. Care is given more often to employees only than to their families.

16. Health instruction to employees' families is given by nurses in a few establishments.

17. The work nurses may be called on to do other than that of a professional nature, will be in connection with workmen's compensation or clerical work.

18. The average working week of nurses in commercial and industrial concerns is 48.8 hours. This is higher than the working week of nurses employed by official and non-official agencies engaged in public health nursing.

REGISTRATION OF SOCIAL STATISTICS

The registration of social statistics, formerly a joint project of the National Association of Community Chests and Councils and the local community research committee of the University of Chicago, was taken over by the Children's Bureau, United States Department of Labor, on July 1, 1930. The community chests and councils will continue to assemble from local institutions and agencies in 39 metropolitan areas data which will be tabulated and analyzed by the Children's Bureau. The Children's Bureau will continue the program of the joint committee with but slight modification, including gathering statistics on public health nursing. The bureau expects to receive much assistance from the joint committee which initiated the work and which will be continued with some changes as an advisory committee to the Children's Bureau.

The cities participating in the registration for 1930 are Akron, Berkeley, Bridgeport, Buffalo, Canton, Chicago, Cincinnati, Cleveland, Columbus, Dayton, Denver, Des Moines, Detroit, Duluth, Grand Rapids, Harrisburg, Hartford, Indianapolis, Kansas City, Lancaster, Louisville, Minneapolis, Newark, New Haven, New Orleans, Norfolk, Omaha, Orange, Richmond, Sharon, Sioux City, Springfield (Ill.), Springfield (Mass.), Springfield (Ohio), St. Louis, St. Paul, Washington (D. C.), Wichita, and Wilkes-Barre.

U. S. Monthly Labor Review

A. W. McMillen, Director of the Committee on the Registration of Social Statistics, writes in his report on the data received from public health nursing agencies as follows: "The figures submitted by the public health nursing agencies are among the most trustworthy that have been assembled in the Registration of Social Statistics."

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

FALL EXECUTIVE COMMITTEE MEETING

The Executive Committee of the N.O.P.H.N. met on October 6 in New York City for its fall meeting. The attendance was most satisfactory: eight members from the Committee itself, three members from the Board, three Presidents of S.O.P.H.N.s, and representation from the N.O.P.H.N. staff.

The most important item of business was the 1931 budget. On the recommendation of the Finance Committee, the Executive Committee unanimously passed an expense budget of approximately $110,000. This represents practically the estimated expense for 1930, except for a reduction of $3,750 due to the fact that 1931 has no Biennial Convention. The Executive Committee paused, and asks you to do likewise, over one phase of the analysis of the estimated income. Only $34,500 of this income comes from membership dues—individual and corporate. The rest of the income is derived from special large gifts from a very few individuals; a group of regular contributors; payment for service rendered; and subscriptions and advertising from the magazine.* It will be necessary to draw upon the accumulated balance from past years to the extent of $6,840. The question which the Finance Committee raised with the Executive Committee was this: Should not a larger proportion of the income come from the membership who receive the benefits of the organization, so that the N.O.P.H.N. may be less dependent upon a few individuals? It was recognized that both individual and corporate membership should be appreciably increased for the sound financing of the organization and the extension of its services. The 1931 budget represents practically no increases in expense or service. Although there is much need to enlarge the program in order to meet opportunities awaiting us and to respond to the calls that come in, it was agreed that the answer to this question remains with the membership.

Up to the present the organization has paid the expenses of only the Executive Committee to board or committee meetings. This has limited the attendance of board members and consequently the geographical representation in the administration of the organization. Therefore the Executive Committee voted to invite the whole board to the meetings in January, 1931, with expenses paid.

REPORT OF REVISIONS COMMITTEE

One of the most important reports presented to the Committee was that from the Revisions Committee, the substance of which was as follows:

> The Revisions Committee is making a survey of the present state branches of the N.O.P.H.N. During the next biennial period every effort will be made to have the N.O.P.H.N. give more effective service in the development of these branches. The Committee will make a careful study of the best form of organization in a state for furthering the public health nursing program.

Certain definite recommendations were made by the Revisions Committee to the Executive Committee and approved, the following being the outstanding ones:

1. THAT the N.O.P.H.N. staff be authorized to study and encourage where it seems desirable, lay sections in S.O.P.H.Ns.

* Income from subscriptions and advertising covers all but $5,000 of the expense of the magazine.

2. THAT the staff be authorized to study and encourage in states where there are no S.O.P.H.Ns. and where it seems desirable, some sort of lay organization which would have sustaining corporate membership in the N.O.P.H.N.

3. THAT joint membership and joint dues in the S.O.P.H.N. and the N.O.P.H.N. be favorably considered as a possible requirement in the development of branches. This would mean that any member, corporate or individual, of a branch must also be a member of the N.O.P.H.N. This question was discussed at a meeting of S.O.P.H.N. presidents at the Milwaukee Convention and unanimously approved by them. The Committee felt that the experiment should be tried out in one or two states during the next biennial period, the results carefully studied, and the question presented for consideration at the next Biennial Convention in 1932.

4. THAT the approval of the A.N.A. be asked for the N.O.P.H.N. to work with public health nursing sections of State Nurses Associations in relation to their program and to work through them as through the S.O.P.H.Ns.; the State Nurses Associations and the A.N.A. to retain their relationship in regard to all matters of organization.

5. THAT the name "Revisions Committee" be changed to "Organization Committee," that the Committee have two functions: (1) to consider problems regarding the best methods of organizing state forces for public health nursing; (2) to act as revisions committee of the N.O.P.H.N. It was felt that a subcommittee on revisions of this Organization Committee could be appointed prior to each Biennial.

REPORT OF EDUCATION COMMITTEE

The Education Committee reported on the new Activity Record for Nurses, published in the November number of THE PUBLIC HEALTH NURSE, and is considering the question of staff education. The Committee thinks this term is misleading and certainly needs careful definition. It is necessary to know what properly may be included in such a classification, in order to analyze the costs—and community chests, board members, and insurance companies are all raising the question of costs. The problem presented is how to distinguish in the so-called staff educational processes between what is done for efficient administration and what is more clearly educational. Can or should this be distinguished? Part of the supervisor's relation to the staff is for the purpose of administration, part for staff education. The problem before the Education Committee is to define and differentiate the processes, if possible, while the Service Evaluation Committee will translate them into cost.

Other projects upon which the Committee is working are the revision of the objectives of school nursing, to serve as a basis for a reconsideration of the suggested course for this group, and a curriculum for industrial nurses.

The Committee briefly considered the post-graduate courses in public health nursing which have been initiated at Syracuse University, Vanderbilt University, and Fordham University, and noted that the University of Colorado, Fisk University, and the University of New Mexico are all considering courses.

There was much discussion of the report of a subcommittee of the Education Committee on the revision of the standard qualifications for staff and supervisors. This will shortly be in shape to present to the A.P.H.A. It was noted that there was great value in having such a statement come from both organizations.

SERVICE EVALUATION COMMITTEE

The Service Evaluation Committee reported that the Metropolitan Life Insurance Company was completing the statistical tables fundamental to the consideration of methods of cost computing, and that the first part of the report which concerns the qualitative factors in nursing service which have a bearing on cost has been prepared by Miss Ann Doyle and has been submitted to the Committee.

1932 BIENNIAL CONVENTION

At the Milwaukee Convention the membership voted to leave it with the Board to decide whether to meet with the other nursing organizations at the next Biennial. It was implied in that vote that the Board at its discretion might elect to meet with some other than the nursing groups, but that not more than an interim of four years would elapse before meeting with the

other two nursing organizations. The Executive Committee had to make a decision at this meeting, as plans for the 1932 Convention are beginning to be formulated. It was voted that in 1932 the N.O.P.H.N. meet with the nursing groups at San Antonio, Texas, but that prior to the San Antonio Convention a decision should be made regarding the 1934 convention. The Committee felt that its own membership was not sufficiently familiar with the N.O.P.H.N.'s present activities and therefore it would be well to have its program for the next Biennial center around material relating to the N.O.P.H.N. projects and functions, and urge the other two nursing organizations to include more public health material in their programs, with the N.O.P.H.N. assisting them in every way possible in developing such a program.

Two more members were appointed to the Nominating Committee for 1932:

Katherine Hagquist, State Supervising Nurse in the Bureau of Child Hygiene of the Texas Department of Health.
Helen E. Bond, Director of the Savannah, Georgia, Health Center.

Three members of the Nominating Committee were elected by the membership in 1930, two members therefore being appointed by the Board in accordance with the By-Laws.

N.O.P.H.N. INDUSTRIAL NURSING SECTION MEETING

There were approximately 200 in attendance at the N.O.P.H.N. Industrial Nursing Section meeting at the National Safety Congress in Pittsburgh, at which Mrs. Hodgson represented the N.O.P.H.N. The papers were good and well presented. Free and lively discussion followed each paper.

Mrs. Austin Levy, lay member of the Executive Committee of the Section, made an interesting contribution to the subject of industrial nursing from the viewpoint of management. Mr. Levy owns a number of small plants in New England and Virginia. One of the plants in Rhode Island is supplied with nursing service by a full-time nurse, and the Visiting Nurse Association supplies part-time service in Smithfield.

Following the program, there was a short meeting of the Executive Committee of the Section when it was decided that "Education" would be the theme of the program for the next meeting with the National Safety Council. The Executive Committee is to act as an advisory program committee, submitting suggestions for topics and speakers to the N.O.P.H.N. office. The mechanics of securing speakers and arranging program is to be left to the N.O.P.H.N. staff.

PROGRESS REPORT OF THE JOINT COMMITTEE ON DISTRIBUTION OF NURSING SERVICE

This committee has had one meeting held in Milwaukee on June 14, at which time the objectives of the committee were outlined as follows:

To develop standards of hourly and group nursing
To organize Councils to study the needs of communities for nursing service.

The committee was broken up into three sub-committees as follows:

Hourly Nursing—Geneva Hoilien, Chairman
Group Nursing and general nursing in hospitals—Shirley Titus, Chairman
Nursing Councils—Emilie G. Sargent, Chairman

Each of these sub-committees is working on a preliminary report to be submitted to a meeting of the whole committee to be held in January. Meanwhile, two letters have been sent to the states encouraging the formation in each state of a State Committee on Distribution of Nursing Service to study the problems of nursing distribution in the state; and to act as a clearing house in the state through which the national Committee on Distribution of Nursing Service may both distribute and receive information.

It has been further suggested to the states that the organization of the State Committee on Distribution of Nursing Service follow the same outline as that used by the national committee. This includes the suggestion that already existing committees on registries, hourly nursing, group nursing, etc., be tied closely to the State Committee on Distribution of Nursing Service by being recognized as sub-committees of it. This follows the proposed plan of considering the Registry Committee of the American Nurses' Association as a coöperative committee of the joint Committee on Distribution of Nursing Service. Ella Best of the staff of the A.N.A. has been made an *ex officio* member of the National Committee on Distribution of Nursing Service and in the contacts that she is making with registries as part of the A.N.A. program, she will keep closely in touch with the national committee.

Regarding hourly nursing, it is urged that inquiries pertaining to hourly nursing from the standpoint of registries be addressed to the A.N.A. and inquiries from the standpoint of public health nursing organizations be addressed to the N.O.P.H.N.

The personnel of the committee is as follows:

Representing American Nurses' Association

Mrs. Genevieve Clifford, Syracuse, N. Y.
Mrs. Lucy Last Van Frank, Chicago, Ill.
Alice Sutherland, Detroit Mich.
Jeannette Hays, Milwaukee, Wis.
Marguerite Wales, New York City
Elnora E. Thomson, Janet M. Geister, Ella Best } *Ex officio*

Representing National League of Nursing Education

Mrs. Anne L. Hansen, *Chairman*, Buffalo, N. Y.
Shirley C. Titus, Nashville, Tenn.
Grace Phelps, Portland, Ore.
E. A. Welley, Fayetteville, N. C.
Susan C. Francis, Philadelphia, Pa.
Anna D. Wolf, Chicago, Ill.
Claribel A. Wheeler, St. Louis, Mo.
Elizabeth Burgess, Nina D. Gage } *Ex officio*

Representing National Organization for Public Health Nursing

Winifred Rand, Detroit, Mich.
Elizabeth Fox, New Haven, Conn.
Juanita Woods, Richmond, Va.
Geneva Hoilien, Albany, N. Y.
Emilie G. Sargent, Detroit, Mich.
Sophie C. Nelson, Katharine Tucker } *Ex officio*
Alma Haupt, *ex officio, Secretary*

PERSONNEL OF N.O.P.H.N. COMMITTEES

(Continued from November)

Advisory Council

(See title page in front advertising section.)

Service Evaluation Committee

Dr. Haven Emerson, *Chairman*, New York, N. Y.
Elizabeth M. Folckemer, Cleveland, Ohio.
Mary S. Gardner, Providence, R. I.
Mrs. Anne L. Hansen, Buffalo, N. Y.
Theresa Kraker, New York, N. Y.
Mrs. Adrian Van Sinderen, Brooklyn, N. Y.
Marguerite Wales, New York, N. Y.
Mabelle S. Welsh, New York, N. Y.

Representing the N.O.P.H.N. on the *Common Activities Committee*

Elizabeth Stringer, Brooklyn, N. Y.
Ellen Buell, Syracuse, N. Y.
Anna A. Ewing, Newark, N. J.

Representing the N.O.P.H.N. on the *Joint Committee for Financing Grading Plan*

Mrs. Anne L. Hansen, Buffalo, N. Y.
Katharine Tucker, New York, N. Y.
Gertrude Bowling, Washington, D. C.

ANNUAL MEETING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The 59th Annual Meeting of the American Public Health Association held in Fort Worth, Texas, October 27–30, 1930, will long be remembered by those attending. Its characteristics were the delights of Texas hospitality and weather, the excellent practical arrangements for housing meetings and exhibits all in one hotel—and the rich variety of papers on many public health subjects given by leaders not only from all parts of the United States but from Canada, Mexico and Cuba as well.

The keynotes struck were the value of close interrelation of persons and organizations active in health service, and the educational aspect of the health

movement as a whole. Throughout it was possible to realize that public health nursing is not a separate entity in itself but an integral part of the larger movement of public health.

The business meeting of the Public Health Nursing Section was attended by about a hundred nurses and was presided over by the chairman, Grace Ross. Following a report by Agnes Martin, chairman of "The Committee to Study Lay Committees Advisory to Official Public Health Nursing Services," this significant resolution was unanimously adopted and sent to the governing council of the A.P.H.A.:

"That an official public health nursing organization suggest to the health officer that a lay advisory committee be formed entirely as an experiment for a period of two or three years. That the committee be organized when conditions are favorable and not when the service or organization is in difficulties.

Aims of Advisory Committee:

To develop a community interest and appreciation of official nursing services.
To be familiar with professional standards in public health nursing.
To assist in securing an adequate number and adequate preparation of personnel.
To secure proper facilities for carrying on an efficient service.
To speak intelligently for the official service.
To maintain a permanent nursing service.
To assist in securing the financial budget required to meet these aims."

The following officers of the section were elected:

Chairman—Mrs. Helen C. La Malle.
Vice-Chairman—Elizabeth L. Smellie.
Secretary—Cora M. Templeton.
Councilors for two years (1930–1932)—Mathilde S. Kuhlman, Mrs. Elsbeth Vaughan, Ada Taylor Graham.

Business meetings were only a part of the order of each day. Southern hospitality was in evidence on all sides—each guest received a "Hospitality Book," including tickets for free taxi-rides in "Courtesy Cars," receptions, a southern barbecue, and a true western rodeo. The public health nursing breakfast, with Fort Worth nurses and lay friends as hostesses, was the climax! After such hospitality, we shall be glad to heed the slogan of the waitresses in hotels and the boys in the filling stations, who invariably say "Come back," to come back for the Biennial Convention of the three national nursing organizations to be held in the beautiful city of San Antonio in 1932.

ALMA C. HAUPT

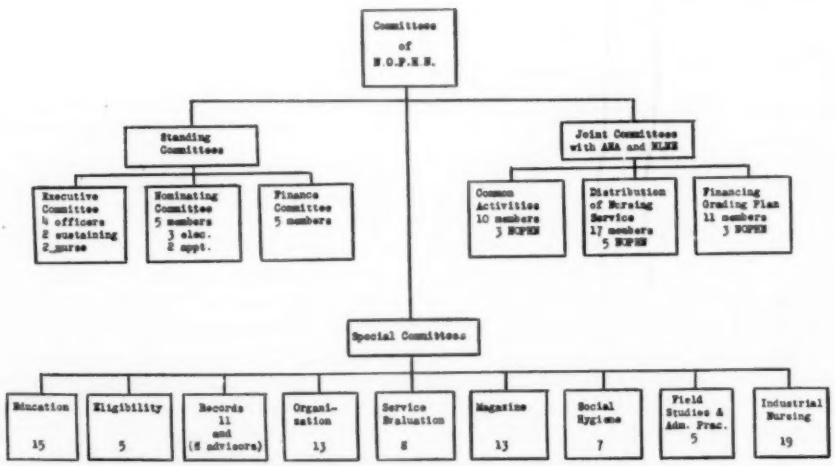

Chart III. The Committees of the N.O.P.H.N.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

REPORTS OF STATE MEETINGS OF BOARD MEMBERS

At the meeting of the State Nurses Association in Burlington, Iowa, October 9th, Mrs. G. Decker French of Davenport, presided as chairman of the State Lay group. Mrs. French in opening the meeting gave a history of the Lay Institute of Public Health Workers. She emphasized the purpose of the Institute as the education of board members.

Miss Alice Whipple, Ladies' Industrial Relief Society, Davenport, discussed the chances for possible conflict between the social workers and public health nurses: first in the routine of reporting; second, in the failure of each to comprehend the work of the other; third, in the lack of understanding of follow-up work. All of which conditions could be adjusted by joint meetings between the social worker and the nurse.

Mr. Robert E. Neff, Administrator of University Hospital, Iowa City, spoke of the rapid development and coördination of the various agencies and health centers, and the importance to public health of both state and private hospitals; also of the value of research in the prevention of disease.

Miss Anna A. Johnson, County Superintendent of Schools, Fort Dodge, outlined the plan of county welfare. The county supervisors grant to the committee $325 per month for health work. This committee is composed of thirty members, one from each township; seventeen farmers' wives being on the committee. Each member is responsible for the health program in his community, reporting at a general meeting once a month.

Miss Johnson stressed the value of the county nurse and the social worker; their aid in helping backward children being invaluable. She called attention to the benefits of the Iowa Dental Plan, and the necessity of publicity in public health procedures.

Mrs. S. J. Delarue, State President of the Dr. Jennie McKowan Circle of King's Daughters, gave an interesting history of the circle, the object of which is to bring aid and comfort to the sick and poor.

Miss Lucy Minnigerode, of the United States Public Health Service, Washington, D. C., told how the service protects the United States from foreign disease through the exercise of quarantine measures at our ports. It may also function during epidemics of disease within our borders. She illustrated further activities in the safeguarding of travel; prevention of pollution of lakes and streams; inspection of vaccines and serums at their source of manufacture, and medical examination of immigrants. She pointed out the alarming increase in both the incidence and virulence of smallpox in the United States and advocated a campaign for compulsory vaccination.

At the lay luncheon, at which Mrs. Hollis Rawson of the Visiting Nurse Association of Des Moines presided, the following officers were elected: Chairman, Mrs. G. Decker French, Davenport; Vice-Chairman, Mrs. L. F. Hill, Des Moines; Secretary, Mrs. Ralph Brubacker.

Mrs. F. H. Lamb of Davenport presented "An Experiment and a Question in Medical Coöperation," which we print here.

AN EXPERIMENT IN MEDICAL COÖPERATION

Since the founding of the Davenport Visiting Nurse Association twenty-eight years ago there has been the most cordial relationship between the association and the Scott County Medical Society. During this period, the doctors have given literally thousands of hours of time and service without thought of remuneration. It is needless to say that we are grateful for this aid and the spirit in which it has been given.

Last year the Scott County Medical Society proposed to make a change in the administration of all charitable work. It was recognized by them that certain new economic and social factors required attention. There was a lack

of control and efficiency which needed to be remedied, for example: there was a duplication of effort; any and all charitable organizations felt that they had a call on doctors' services. There was an undesirable political element, and last but not least, nonpaying patients were not receiving the best medical care.

The first step was the organization of the Scott County Medical Society, Incorporated, made up of volunteers from the Scott County Medical Society. Nearly all active members volunteered. As an incorporated body, this new organization had the power to enter into contracts and accept responsibility from the Board of County Supervisors. At a figure agreed upon, the care of the County Poor was taken over by the incorporated Medical Society.

At this point the Medical Society requested the Visiting Nurse Association to provide a room in its building in which daily clinics might be held. This was particularly desirable owing to the location of the V.N.A. headquarters, and the centralization of similar medical work.

After consideration by our Board, it was decided to make a six months' trial of this new plan. Inasmuch as it was admittedly an experiment, the Board felt justified in exercising caution before agreeing to a longer contract. Accordingly the space designated was equipped by the medical society, and a graduate nurse, not of our staff, employed by them, was placed in charge. Her duties consist of helping with clinic patients, and acting as a social worker for the Medical Society, Inc. The clinics are held daily under a rotating service from physicians appointed by the executive committee of the Medical Society.

The medical clinics are separate and distinct from our visiting nurse clinics, which we still maintain: Tuberculosis; Toxin-Antitoxin; Child Welfare; Prenatal; and Dental. Our organization assumes full control of these clinics, and we arrange with the doctors individually for their services. We feel that we have in this way continued to render the service for which we were intended.

After nearly a year, we find that the foregoing plan has been eminently successful: Certainly it is beyond the experimental stage, and thus far there has been no occasion to change the plan either on the part of the doctors or the association. Unless unforeseen circumstances should arise, we feel that we may conservatively renew this working agreement with the Medical Society for another year.

The question of a part-pay clinic has been casually mentioned. Many of the larger centers report varying degrees of success with this type of medical service. Should this question become an issue with our organization, it would require a decision embracing an entirely new principle. Our organization is maintained, our splendid building was built, and we function entirely through funds donated and received for charitable purposes, the sole exception being a minor fee service which in no way interferes with the primary object of the organization. The operation of a part-pay clinic, therefore, would, we feel, be misunderstood by contributors upon whom our activities depend. Even though the part-pay clinic were owned and operated by another organization, its activities would always be identified with the V.N.A. Clearly as we may understand the distinction, the public could not be expected to do so. We would value discussion of this question and the experience of any other group working under a similar plan.

CONNECTICUT STATE MEETING

In Connecticut board members are becoming increasingly active, and self-education is the watchword of the day. At the usual meeting of the Board Members' Organization of Connecticut Public Health Nursing Associations, held recently at the same time and place as the meeting of the Graduate Nurses' Association, 125 board members listened to inspiring

accounts of the Milwaukee Convention, one by their own representative, giving the lay point of view, and the other, a most enthusiastic paper by a young nurse who told of the special points which had interested her. At luncheon, following a suggestion of the chairman, each one sought to gather information from another association by "sitting next to some one she had never seen before." Many were the valuable bits of experience exchanged in this way.

Contrary to the usual custom of attending the nursing sessions in the afternoon, two round tables for board members were arranged. At one of these the city associations (those employing eight or more nurses) discussed their immediate problems, such as: How shall one produce leadership in a board? while at the other the interests of the small town and village associations were considered under the leadership of the Education Committee of the Board Members' Organization. Such topics as mental hygiene, hourly nursing, the medical advisory board and how to use it, interpretation of records and the advantages of making charts of conditions in associations were brought forward.

The long-awaited *Board Members' Manual* proved its worth, and in accordance with the information given on page 87, the Connecticut Board Members' Organization voted to become a Sustaining Corporate Member of the N.O.P.H.N. A careful review of the *Manual* was given by the Education Committee and board members were urged to use it as a text book. Copies were on sale and were taken home by many eager board members.

The general feeling was that the chance to discuss board problems with those who work under the same conditions was eminently desirable but that it must not be allowed to interfere too often with our meeting directly with the nurses.

NEW YORK STATE MEETING

The blizzard that raged in Syracuse on the morning of Tuesday, October 21, was not sufficient to dampen the ardor of the nurses and lay members, who had gathered from all parts of the state for the annual meeting of the state nursing organizations.

At the Joint Session, held in the evening, in the ball room of the Hotel Syracuse, Mayor Rolland B. Marvin gave a bright and witty welcome, to which Helen Wood, First Vice-President of the New York State Nurses' Association, replied. Allan Craig, M.D., C.M., of Chicago then spoke on "Our Hospitals, Our Doctors, Our Nurses, and Ourselves," and the evening closed with a most informative and interesting talk by Elinor D. Gregg, Supervisor of Nurses, U. S. Nursing Service, on "The Indian Service and Other Government Nursing Services," citing the experience of a nurse stationed at the bottom of the Grand Canyon of the Colorado, in charge of a group of Indians, whose nearest hospital was at a distance of twelve miles up the canyon in one direction, plus a trip of fifty miles across the desert. This nurse stuck to her job for three years.

A luncheon was held for members of Hospital Boards, Visiting Nurse Association Boards, Nursing School Committees, and Red Cross Committees, presided over by Mrs. J. Morton Halstead, President of the Brooklyn V.N.A., at which Stella Goostray, Advisor, Joint Nursing Committee on Educational Policies, read a most able paper on "The Community and Nursing Education." Mrs. Anne L. Hansen of Buffalo, past President of the N.O.P.H.N. and now Chairman of the Joint Committee on the Distribution of Nursing Service, gave a short account of this committee's work.*

At the Joint Meeting for Public Health Nurses and Lay Committee and Board Members, Amelia Grant, Director, Bureau of Nursing, New York City, read a paper on "What Kind of Nursing Is Needed in Clinics," and gave the numerous rôles which the nurse must play in this department as hostess, executive, teacher, social service and case worker.**

Miss Louise C. Odencrantz, Director, New York City Employment Center for the Handicapped, gave a graphic account of the work of her organization, stating that many of the Fifth Avenue shops had given employment to the handicapped but the employers of larger forces seemed to be more afraid of the risk. Thomas Parran, M.D., State Commissioner of Health, Albany, told "How Every Graduate Nurse Can Contribute to Public Health Work" and described some of the difficulties encountered in the administration of county work.

The Joint Meeting on Thursday morning was presided over by Marion W. Sheahan, President, New York State Organization for Public Health Nursing, and the first address was given by Emma Grant Meader, Ph.D., Lecturer in Education, Troy—the subject, "The Philosophy and Psychology of Supervision, Especially Applied to Nursing." What might well have been a dry subject was made intensely interesting by Dr. Meader's witty and most human treatment and this was felt to be one of the most outstanding papers of the convention. Gladys Sellew, Assistant to Dean, Cook County Hospital School of Nursing, Chicago,

* See page 640 of this magazine.

** It is hoped that Miss Grant will write out this address for this magazine.

spoke on "Supervision of the Graduate Staff of Nurses in a Hospital," and Mabelle S. Welsh, Associate Director, East Harlem Nursing and Health Service, closed a most inspiring morning with a splendid thesis on "Supervision of the Graduate Staff of Nurses in Public Health Organization."

The Board Members had a closing session at which Mrs. William B. Gere, Member of the Lay Committee on Arrangements, presided. Dorothy Deming, Editor of THE PUBLIC HEALTH NURSE, spoke on "Professional Reading" and gave many helpful points on how the work of reading and reporting on health reports, magazine articles, etc., might be allotted to board members and brought to board meetings. Mrs. Linzee Blagden, Vice-President, Board of Managers, Bellevue School of Nursing, New York City, gave "The Functions and Usefulness of a School of Nursing Committee." The closing paper was a most interesting one by Mrs. Roessle McKinney, President of the Albany V.N.A., on "Why be a Member of a Professional Organization." She gave a set of Ten Commandments for board members which were most illuminating. Among them were:

Know why your organization exists. Give money or help get it, or both. Face budgets with determination, endowments with doubt, deficits with courage. Know your staff personally. Keep far enough ahead of your community to be progressive. Combine a New England conscience with an Irish sense of humor.

Too much credit cannot be given to those responsible for the mechanism of this convention or to those who compiled the program. The very common mistake of having a three-ring circus going on was avoided and ample time given for the various sessions. Student nurses acted as ushers and evidently had the thrill of their young lives. A Parliamentary Law Class was conducted by Sherman L. Kennedy, Professor of Forensics, Syracuse University, and many availed themselves of this opportunity. The whole spirit of the convention, both of the professional and lay groups, was most inspiriting and the quality of the addresses reached an unusually high mark.

PENNSYLVANIA STATE MEETING

The regular meeting of the Lay Members Section of the State Organization of Public Health Nursing was held Thursday, October 30, 1930, at the Woman's Club, Allentown, Pennsylvania, with Mrs. M. B. Fuller presiding.

The morning session opened with a very instructive talk by Mrs. G. Brown Miller of Washington, D. C., outlining the method of use of the *Board Members' Manual*. How to make a board meeting interesting was discussed by Miss Howe of Philadelphia. A general discussion followed on different types of work carried on by the organizations represented. Miss Davis, Assistant Director of the N.O.P.H.N., gave a most stimulating account of the work of lay sections throughout the country. Miss Stack of Connecticut spoke briefly upon the lay organization in her state.

A resolution was adopted to be presented at the next business meeting of the State Organization: That the Pennsylvania Lay Section organize on a state-wide basis, with an Executive Board, composed of officers, two nurse advisors, and regional chairmen.

Miss Nelson, President of the N.O.P.H.N., brought greetings and congratulations to this group from the National. Her talk was practical and inspiring, as she discussed in detail the inter-relationship of the lay and professional groups and gave suggestions for a more definite and coherent organization, in order to have the policies and objectives more clearly defined.

The section then adjourned for lunch, as guests of the Allentown Woman's Club.

Following luncheon, Mrs. Fuller introduced the first speaker, Mrs. Walter F. Meyers, who read a report of the Biennial Convention. Mrs. Zimmerman of the Lancaster Visiting Nurse Association described the splendid work of their nutrition department. Mrs. G. d'A. Belin of Scranton spoke upon the place of mental hygiene in a public health nursing program from the board member's point of view, outlining developments in Scranton in this new field of work, under a special mental hygiene supervisor.

Mr. Ludwig, President of the Reading Visiting Nurse Association, spoke of the responsibilities for the control and prevention of communicable disease and described the ideal of coöperation among all the health agencies in his community.

Eighty-four delegates registered, representing twenty-nine different communities.

REVIEWS AND BOOK NOTES

Edited by RUTH GILBERT

THE WORLD OF THE BLIND: A PSYCHOLOGICAL STUDY

By Pierre Villey. The Macmillan Company, $2.25. Translated by Alus Hallard.

This book, awarded a prize by the French Academy of Moral and Political Science as "the best work of recent years on the subject of the psychology of the blind" might well be taken as a textbook by whoever wishes once and for all to secure a penetrating understanding of the blind. The author himself is blind. He has a great desire to make those who see understand those who do not see. He feels the double handicap, of being blind and of not being understood.

Everyone has an urge to be like his fellows and to be respected as a whole personality. We do not like to be looked down upon as crippled. We want our assets rather than our liabilities stressed. "Pity the poor blind man" is not the note of this book. Rather is it, "See the blind man's capacities. They are as real as yours." Help is needed by the blind to make them vocationally efficient, but then everyone needs help in this and with the blind it is only a matter of degree.

M. Villey does much to dispel certain fallacies about the blind. The blind are not inferior. They may be of all grades of mentality. Conversely, they are not superior. Their remaining senses do not innately have marvelous properties. The same capacity of developing special sensitivity of the remaining senses exists in all.

Step by step, touch by touch, by the medium of sound, of investigation, of imagination, of study, of a hundred and one methods, this absorbing book thoroughly orients us in the world of the blind, and we make the surprising discovery of how blind we have been, how unimaginative in our concept of the mental life of the blind.

Of course it is natural for us not to sense readily this different world of existence. And it is natural for us to draw back a little because we find it difficult to imagine how life could be bearable without the precious gift of sight. But the public health nurse who finds a blind person in the home will after reading this book be in a better position to consider him as a normal person with a handicap instead of an incomplete personality. To achieve this result was M. Villey's aim and he has admirably succeeded.

The chapter on the author's own experience, describing how he was able to undertake an intensive piece of literary research is well worth reading, although the author modestly apologizes for the personal illustration. Certain chapters are rather profound, such as those on The Substitution of Images and the Furniture of the Mind. Other chapters earlier in the book are more simple and explanatory and filled with most interesting detail. All of it makes fascinating reading.

KATHLEEN O. LARKIN

INFANT NUTRITION

By W. McKim Marriott, M.D. C. V. Mosby Company, St. Louis. $5.50.

Dr. Marriott has brought together in a very interesting way a summary of present day knowledge and thinking on the subject of infant nutrition, and has highlighted certain "whys" as well as "hows" from his own wide experience, producing a volume interesting in makeup, challenging in simplicity and of decided value as a text for the medical practitioner and as a reference for those nurses and nutritionists whose chief responsibility is the education of the family as to their nutritional needs.

Nurses particularly will find the book interesting and extremely helpful as it so thoroughly goes into the funda-

mentals of normal nutrition followed by a careful delineation of the causes, symptoms and treatment of abnormal conditions relating to nutrition.

SARA B. PLACE

THE PRINCIPLES AND PRACTICE OF HYGIENE

By Dean Franklin Smiley, M.D., Adrian Gordan Gould, M.D., and Elizabeth Melby, R.N. The Macmillan Company, New York, $2.50.

This book would be a valuable asset to the personal library of every nurse. The authors take a broad, wholesome, new view of an old subject, handling it scientifically, concretely, and interestingly.

The subject is clearly organized into ten sections. The introductory section consisting of four chapters deals with "The Nurse as a Student and Teacher of Hygiene," "The Health Program of School Nursing," "Factors Producing Ill Health," and "Growth, Health and Education." The following statement in the second chapter suggests the authors' aim: "At the beginning of our study of hygiene in the school of nursing, therefore, let us clear our minds of any past misconceptions about the subject, let us stop considering hygiene as a mere collection of trite opinions and simple thumb-rules concerning health and look upon it as the science of safeguarding and promoting human health and vitality, a subject neither simple nor trite but bristling with unsolved problems, and one of the most practical studies the student will pursue in her nursing course."

Some helpful features of the book as a text and reference are: clear organization of the subject matter; brief summary of the important points included in each chapter; a generous supplementary reading list in connection with each chapter; a glossary of technical terms; an index; valuable illustrations, tables, and diagrams; and a discussion of scientific principles, recent scientific experiments and thought in connection with the theories of hygiene advanced. Undoubtedly the last mentioned feature is one of the greatest assets of the book because the biological principles are described in a manner which make them easy to comprehend and significant, and the subject interesting and convincing.

Some unique discussions of the following topics are included: health upkeep rating table based upon physical examinations and health habit inventory; smoking in relation to hygiene; mental hygiene problems in apparently normal people, the martyr, the pouter, etc.; the abnormalities and mechanism of sleep; play in student and adult life; the health educational responsibilities of the nurse; and health and hygiene in personal attitudes.

This book should be helpful to all those who are interested in health education, including parents, teachers, physicians, and particularly nurses.

MARY MARVIN WAYLAND

GROWTH AND DEVELOPMENT OF THE YOUNG CHILD

By Winifred Rand, B.A., R.N., Mary E. Sweeney, M.S., M.A., and E. Lee Vincent, Ph.D. 394 pages. Illustrated. W. B. Saunders Company, Philadelphia. 1930. Price, $2.75.

The authors of this book are, in order, specialists in the field of parental education, physical growth and mental growth. Their professional association at the Merrill-Palmer School, Detroit, has made it possible for them to present an extremely unified and well coördinated discussion of child growth and development. They have had a wealth of material from which to make their observations, and there is no "armchair theorizing" about this little volume.

Too many books on child development consider neither the background nor the foreground of the child as though he were an isolated being who had just sprung up and, like Topsy, just "growed." This book opens with a very frank discussion of the philosophy of marriage and the factors which contribute to wholesome family life. The prenatal development of the child as well as the prenatal care of the mother is considered. It will be seen, therefore, that there is an extremely valuable background on which to pro-

ject the discussion of the child and his mental and physical development as well as his emotional and social life. The book constantly keeps in mind those factors which not only make for a healthy, happy childhood but the achievement of a well rounded adult personality.

Appended to each chapter there is a list of reference books for supplementary reading, and the bibliography at the end gives the publisher of the book as well as the date of publication. The book compels attention. One of the sound criticisms made of nurses is that they know little about the normal child. We hope this book will find its way into the library of every School of Nursing, and it might well be added to the bookshelf of every public health nurse who is concerned with child health and development.

STELLA GOOSTRAY

For Use with Children

Are You Training Your Child to be Happy? is a 1930 publication of the Children's Bureau, U. S. Department of Labor. This pamphlet is designed for use as lesson material in child management. Twelve lessons are prepared covering such subjects as "How can you help your child to form good habits," "How Parents Teach their Children to be Naughty," "Does Your Child Have Bad Physical Habits," "Are You Helping Your Child to Grow Up." The language in which these lessons are couched is so simple that the group to which the pamphlet may be offered is unfortunately limited. Principles and methods offered for use are generally applicable, but only parents who are learning English or whose background is extremely limited could be offered the material as it stands. Probably this lesson material has two distinct values. It may be offered directly to the type of parent described or it may be re-interpreted by nurse or social worker for use with other groups. The title is an indication of the very real value of the pamphlet.

The over-dependent child who is not interested in play; the over-active child whose real interests have not been developed; the child of scattered interests, are problems which the public health nurse meets in her home-visiting. The nurse hesitates to advise the mothers of such children because of her limited knowledge of constructive play material. The Work and Play Series, published by Macmillan, will be helpful both in the above situations and when "small boys and girls want to play with hammer and nails and long to make something. . . ."

The Series includes the following: *Your Workshop, Playing with Clay, With Scissors and Paste, The Piece Bag Book, Beginning to Garden, The Box Book, Working with Electricity.* The titles indicate the age group for which each book is intended. Price $1.50–$1.75.

These two articles on problems often closely allied will help to clarify our somewhat confused information in these matters.

Left-Handedness by Dr. Ira S. Wile appearing in the Parents' Magazine for October, is an understandable, informative article on this subject. Dr. Wile urges consideration of the possible consequences, before trying to convert a left-handed child into one who uses the right hand.

"There is only one method of curing stuttering permanently. Exercises given to improve the voice and pronunciation and to establish control of breathing offer only temporary relief." This is a brief excerpt from *The Mental Hygiene of Speech,* a radio talk by Frederick W. Brown reprinted in the Mental Hygiene Bulletin for October.

From Allied Fields

Nurses who interpret their professional interests broadly will be interested in two recent publications of The New York School for Social Work. *The Dependent Child* by Henry W.

Thurston is a study of the changing aims and methods of care of children in dependent situations. Price $3.00.

The first series of lectures under the Forbes Leadership was given by Amy Hewes as an attempt of the field of economics to answer some of the questions harassing those who deal with family problems. These lectures are published under the title, *The Contribution of Economics to Social Reform.* Price $2.00. Both are obtainable from the Columbia University Press, 2960 Broadway, New York City.

The Social Work Year Book for 1929, published by Russell Sage Foundation ($4.00) is now available. This reference volume includes a roster of national agencies as well as an encyclopedic description of social work events and developments of the year.

New Editions

New editions of Proudfits' *Nutrition and Diet Therapy* and Blumgarten's *Textbook of Materia Medica* have been issued. These textbooks have so long been a part of our equipment that they need no word beyond a welcoming of "this year's model." Both are Macmillan books, price of the former $2.75; of the latter $3.00.

Young's *Handbook of Anatomy* is also in revised form, price $3.75, from the F. A. Davis Company, Philadelphia. The clarity of even the more complicated diagrams is unusually excellent.

A second edition of Williams' *Hygiene and Sanitation* has been published by W. B. Saunders Company, Philadelphia. Price $2.00.

Last month the American Journal of Nursing completed *Thirty Fruitful Years* of service to the nursing profession. A pamphlet descriptive of the growth and activities of the magazine is available at headquarters. *Proceedings of the Twenty-Seventh Convention of the American Nurses' Association*—the Milwaukee Convention—are also now available. Price 75 cents.

Health Education material is offered by the Dairymen's League Cooperative Association, Inc., 11 West 42nd Street, New York City, by means of a catalogue of books, posters, leaflets, exhibits, etc., available from that organization. The catalogue includes instructions for ordering.

The Evaporated Milk Company of Chicago has an artistically colored poster of a mother and baby which would add beauty to any conference room. It carries no slogan and has ample room for a local message. *Eating for Efficiency,* revised version, gives good food tables and suggests recipes with the food value of the latter.

A World Panorama of Health Education, a report of the Health Section of the World Federation of Education Associations which met at Geneva in 1929 has been published jointly by the American Child Health Association and the Metropolitan Life Insurance Company. School nurses will be especially interested in comparisons between school health procedures in many countries. The next meeting of the Associations will be in Denver in the summer of 1931.

Anyone who feels that Florence Nightingale belongs strictly to a past era should refresh her imagination by reading *Trained Nursing for the Sick Poor* in the International Nursing Review for September, 1930. The greater part of this material originally appeared in a letter written by Miss Nightingale to The Times. The problems dealt with in the paper are not altogether similar to our own but the effort toward community organization remains our problem still. "Allow an old nurse to say her word on the system (district nursing) which twenty years ago was a paradox, twenty years hence will be a commonplace."

Incidentally, the International Review offers an opportunity to brush up a bit on French and German. Articles are printed in English with digests in both the above-mentioned languages.

NEWS NOTES

On August 15th the eleventh International Course in Public Health for Nurses and the seventh International Course for Nurse Administrators and Teachers in Schools of Nursing opened in London. These courses are conducted by the League of Red Cross Societies and in connection with Bedford College for Women and the College of Nursing. Theoretical work at Bedford College began on October 1st, but great importance is attached to the preliminary six weeks' practical course, when the students are assigned to health centers and hospitals for observation and study, to familiarize themselves with English nursing measures and health procedures.

Following are the International Students registered for this year's course:

COURSE FOR NURSE ADMINISTRATORS AND TEACHERS IN SCHOOLS OF NURSING

Violetta Besesti	Italy
Zafira Christova	Bulgaria
Phorn Diskul	Siam
Thora Gudmundsson	Iceland
Elza Nulle-Siecenieks (Mme.)	Latvia
Elisabeth Petschnigg	Austria
Irmgard Staehle	Germany
Enni Voipio	Finland
Jadwiga Zukowska	Poland

COURSE IN PUBLIC HEALTH FOR NURSES

Eveline M. Crothers	Great Britain
Irmgard Fussenegger	Austria
Eleanor J. Merry	Great Britain
Gladys Parker	Great Britain
Eliamma Thomas	India

The National Conference of Social Work will meet in Minneapolis, June 14–20, 1931.

Courtenay Dinwiddie has been appointed executive secretary of the National Child Labor Committee. Mr. Dinwiddie succeeds Owen R. Lovejoy.

The Public Health Nursing Division of the City Department of Health, Memphis, Tennessee, has recently been requested by the Schools of Nursing of the following hospitals — St. Joseph's, Memphis General and the Gartly-Ramsey—to arrange an affiliation for their students of two months' practical experience in public health nursing. It is hoped that this will continue for selected students at two months intervals. At the present time five students are enjoying this affiliation, and will also be enabled to attend the Maternity Center Institute December 4th and 5th, held under the auspices of the city of Memphis, Department of Health.

Dr. W. Frank Walker, formerly field director of the Committee on Administrative Practice of the American Public Health Association, has joined the staff of the Commonwealth Fund.

On November 1st, the Bellevue-Yorkville Health Demonstration in cooperation with the New York City Health Department, the New York Tuberculosis and Health Association and the American Social Hygiene Association opened an intensive social hygiene campaign. The objects of this campaign are to inform every resident in the district of the risks of the so-called "social diseases," syphilis and gonorrhea, and to get as many infected individuals as possible under good medical care. Physicians, clinics, hospitals, nurses, religious, civic, industrial and social work organizations are

working with the health agencies in the effort. The campaign has received the endorsement of the Medical Society of the County of New York. In its thoroughness and comprehensiveness, it is the first of its kind in the United States.

Home safety from the point of view of the individual home accident will be the emphasis of the work to be done during the coming year by Gertrude Zurrer, R.N., under a graduate fellowship offered by the National Bureau of Casualty and Surety Underwriters. Miss Zurrer is working at the University of Chicago in the School of Social Service Administration. While figures are available relative to the numbers of accidents taking place in the home, the underlying causes of these and the means of eliminating such accidents through better home management have not been studied. Miss Zurrer's approach will be from the latter angle, where it is felt that her training and experience as a public health nurse will be invaluable.

The regular meeting of the Rhode Island State Organization for Public Health Nursing was held Thursday evening, October 30, 1930, at the Francis W. Carpenter Memorial Building, at 8 P.M., the President, Miss Sara A. Carroll, presiding.

Following the business meeting, a most enjoyable and instructive address was given by Mr. Donald A. North, State Probation Officer, concerning the work of his department, with its constructive results.

APPOINTMENTS

Joint Vocational Service reports the following appointments during October:

Catherine Bastin, instructor of nursing, University of Oregon, Portland School of Social Work.

Doris Beaumont, Mary E. Ritchie and Katherine Stiles to supervisory positions in the Rockefeller Hospital, Peking, China.

Louise Clift Bentley, teaching supervisor, Out-Patient Department, University of Michigan Hospital, Ann Arbor.

Mary Falker, Metropolitan Life Insurance Company, Jamaica, N. Y.

Aslaud Follestad and Mrs. Beatrice Kirkbright to staff positions with A.I.C.P., New York City.

Ruth Garey, staff nurse, Visiting Nurse Association, Orange, N. J.

Dorothea Glasoe, school nurse, Two Rivers, Wis.

Ruth Govier, staff nurse, Neighborhood House, Tarrytown, N. Y.

Helen Hancock, rural nurse, Ocean County Health Association, Toms River, N. J.

Geraldine Hiller as nurse-teacher, Public Schools, New Rochelle, N. Y., and Mary Dempsey to a similar position, Public Schools, Yonkers, N. Y.

Fannie Hurvitz and Mrs. Gertrude Schait Micklin to staff positions with N. Y. Diet Kitchen Association, New York City.

Mabel Lawrence, staff nurse, Frontier Nursing Service, Hyden, Ky.

Grace V. Perry, Child Health Education staff, Association for Prevention of Tuberculosis, Washington, D. C.

Gladys Piper, supervising nurse, Health Unit, Sullivan County, Blountville, Penn.

Anna M. Smith, staff nurse, Visiting Nurse Association, Spring Grove, Pa.

Mrs. Mary Spitzfaden, staff nurse, Visiting Nurse Association, Hackensack, N. J.

Marion Sprague, senior staff nurse, District Nurse Association, Mt. Kisco, N. Y.

Mary Van Zile, tuberculosis supervisor, Visiting Nurse Association, Atlantic City, N. J.

Marie Wall, staff nurse, Eastchester Neighborhood Association, Tuckahoe, N. Y.

Mabel Worden, executive secretary-nurse, Essex County Tuberculosis Society, Beverly, Mass.

Other appointments:

Margaret Reid as Assistant Director of the Public Health Nursing Service for the Eastern Area, American Red Cross.

Margaret Newman, school health work, Tridelphia School District, Wheeling, W. Va.

Catherine Slimpert, district field supervisor, Illinois State Department of Health.

Cora Warrent, formerly assistant director, Public Health Nursing Association, Rochester, N. Y., has been advanced to the position of director.

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